MISSION SUPPORT ALLIANCE, LLC

HEALTH AND WELFARE BENEFIT PLAN

PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

This document is provided for informational purposes only. While it is not intended to provide all the details of the Plan it is intended to help you understand how the Plan works and answer the most frequently asked questions about the Plan. If you still have any questions concerning the terms and conditions of the Plan you may make a request to either the Mission Support Alliance/Market Based Plans (MSA/MBP) Benefits Administrator who was appointed to handle the day-to-day operation of the Plan by the Plan Administrator or to the applicable insurance carrier/claims administrator listed on Schedule B.

Additional material, such as those that may be provided by an insurance carrier, may contain more details concerning the benefits offered under the Plan. While every effort has been made to make certain that the information given to you is consistent between all material, if there is any conflict in this information, the Plan Administrator has the responsibility to interpret the conflicting provisions and determine what benefits will be provided. If a dispute arises out of or in connection with the Plan benefits as described in this document, the dispute will be subject to the exclusive jurisdiction of the state and/or federal courts located in Yakima, WA.

The Plan is maintained for the exclusive benefit of employees and their dependents

The Plan may not be amended or modified through any oral statement by a representative of the Employer or anyone else working with, or in any way related to, the administration or operation of the Plan. If oral statements are made by individuals that conflict with the actual Plan provisions, the Plan provisions will apply; therefore, you should contact the Plan or the applicable insurance carrier or claims administrator for Plan information.

Finally the following information is not intended to create and does not create a contract, expressed or implied, or a guarantee of employment for any specific duration. While the Employer intends to continue this Plan indefinitely, the Employer reserves the right, at its sole discretion, to change any of the contents of this document at any time and without notice by action of the Plan Administrator. The Employer's right to amend or terminate the Plan includes, but is not limited to, changes in eligibility requirements, premiums, benefits provided and cost-sharing as it relates to any group of employees or dependents. Neither you nor your beneficiaries have a vested or non-forfeitable right to receive benefits under the Plan.

IMPORTANT NOTICES

Please note that the document section entitled "Important Notices" includes the following list of attached notices. The notices contain important information concerning your rights under the plan, benefits for which you may be eligible, and what your obligations may be to obtain such benefits. **Therefore, it is important that you read these notices.** If you have any questions concerning the information provided in the notices, please contact Chayne Summers, MBP Benefits Administration, Mission Support Alliance, LLC at 509-376-8833.

The notices include:

1. ERISA Rights Statement
2. Summary - Important Information About Your Health Information Plan Privacy
3. Detailed - Important Information About Your Health Information Plan Privacy
4. Maternity and Newborn Coverage
5. Women's Health and Cancer Rights Act
6. Detail of the Claims Procedures
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PLAN PURPOSE

The Mission Support Alliance, LLC Health and Welfare Benefit Plan (the "Plan") became effective on August 24, 2009 and was revised as of February 1, 2016. The Plan provides benefits as described in this document, the insurance carriers' booklets and the claims administrators' booklets. These insurance carriers and claims administrators are listed on the attached Schedule B. Certain benefits are provided by Mission Support Alliance, LLC (the "Employer") under the Plan at no cost to participating employees. In addition, participating employees may purchase certain contributory benefits on a tax-favored (that is, pre-tax) basis and may create individual spending accounts for medical and dependent care expenses. Other benefits may be purchased on an after-tax basis.

The following information, together with the materials (booklets, certificates, etc.) prepared by the insurance carriers and the claims administrators, form both the Summary Plan Description (SPD) and the written plan document for the purposes of the Employee Retirement Income Security Act ("ERISA") and the Internal Revenue Code (the "Code").

ELIGIBILITY

Eligibility – Regularly Scheduled Employees

If you are a regular employee of the Employer and you are regularly scheduled to work at least 20 hours per week, you are eligible for benefits under the Plan as of your "Entry Date." Your Entry Date is your date of hire as an eligible employee or the date you meet the requirements of an eligible employee.

Finally, for the purpose of the Employer reporting requirements under the Affordable Care Act (ACA), also referred to as health reform, all employees will be monthly measured. This means the Employer will review the hours you actually worked in the previous month to determine your full-time work status for that month.

Eligibility – Other Individuals

Please note that individuals who are classified by the Employer as non-employees (e.g., independent contractors) are not eligible to participate in the Plan. Additionally, more than 2% owners and their dependents may not receive benefits on a tax preferred basis. The Employer may also designate certain other groups of employees (e.g., interns, temporary employees, contract workers, etc.) as not being eligible to participate in the Plan. If you have questions about whether you are eligible to participate in the Plan, you should contact the Mission Support Alliance/Market Based Plans (MSA/MBP) Benefits Administrator.

Eligibility – Dependents

When you become eligible for benefits, your dependents that meet the eligibility criteria described in the insurance carriers' and/or claims administrators' booklet(s) may also become covered for certain benefits as indicated on the attached Schedule A. Eligible dependents for medical and dental benefits include registered domestic partners, and the children of such partners. You may be required to provide proof of your relationship, as required by the Employer, with any individual who you enroll for benefits under the Plan. Additionally, the Employer retains the right to perform a benefits eligibility audits on Plan enrollment.

Please note to the extent permitted by law, claims incurred by an ineligible dependent under the Plan may be denied. Additionally, and as described below, you may be subject to additional taxes based upon the value of the dependent's coverage.

IMPORTANT INFORMATION ON PLAN ELIGIBILITY RELATED TO INCREASED TAXES AND OTHER COSTS

1. If you cover an individual who **does not meet** the following criteria, the IRS requires that you may be subject to additional taxable income based on the fair market value of the coverage (See Schedule E for additional information.)

   - Your legal spouse;
   - Your tax dependent under the Code Section 152; or
   - For benefits related to healthcare, your dependent under Code Section 105(b) or your child who is under age 27 as of the end of the tax year (December 31).

   The fair market value would be reduced by any contribution you paid on a **post-tax** basis for such individuals. However, if your contributions for a non-tax dependent individual are paid on a pre-tax basis, the entire fair market value of the coverage would become imputed income to you with no reduction for the pre-tax contribution amount.

   NOTE: The above information relates to the federal tax code, state and local tax codes may differ and may result in additional taxes.

2. In addition to being subject to additional taxation described above, if you cover an individual who is not otherwise eligible for Plan benefits, the following may also apply.

   - To the extent permitted by law, claims incurred by an ineligible dependent under the Plan may be denied.
   - You may be subject to any disciplinary action as described in the Employer's employment policies and procedures.

If you have any questions concerning who is an eligible plan participant, please contact the Benefits & Compensation Specialist.

MEDICARE ELIGIBLE PARTICIPANTS

With the exception noted below*, if you or your dependents are or become eligible for Medicare, you have the following choices for medical benefits:

- You can elect to enroll in the medical plan option offered under the Plan;
- You can elect to enroll in the medical plan option offered under the Plan and enroll in Medicare;
- You can elect to enroll in only Medicare.

For Medicare Parts A and B, there is no premium penalty if you delay your Medicare enrollment **AND** you are covered under an employer's group medical plan based on active employment. COBRA and retiree medical plans **ARE NOT** considered coverage based on active employment.

For Medicare Part D, there is no premium penalty if you delay enrollment in Medicare Part D **AND** you continue to be covered under a prescription drug plan that is considered to offer creditable coverage. On at least an annual basis, you will be notified about which prescription drug plans offer creditable coverage.

For additional information on Medicare benefits, enrollment rights, and premium penalties, please contact Medicare or go to the Medicare website at www.**medicare**.gov.

*Exception: Based on Medicare rules, if you cover an individual who is not your spouse as defined by the **federal** government, that individual may need to enroll in Medicare when they become eligible for Medicare due to age. If the individual fails to enroll in Medicare, the individual may be subject to the Medicare Part B late enrollment penalties when they do enroll and there may be a delay in the Medicare coverage effective date. Additionally, if the individual continues to be covered under the Plan, Medicare will be the primary payer of claims and the Plan will be the secondary Payer. You should contact Medicare to determine how Medicare will apply to any non-spouse dependent.

RESCISSION OF COVERAGE

The Plan retains the right to rescind (i.e. retroactively terminate) coverage if it is determined that fraud or intentional misrepresentation was used to obtain or continue the coverage. For example, we retain the right to rescind coverage for a dependent that is not eligible for coverage under the plan's terms. In addition, coverage can be rescinded if you fail to timely pay the required employee contribution amount.

- If rescission of coverage is due to fraud or intentional misrepresentation, you will have a 30-day appeal period. If your appeal is not successful, your coverage will be retroactively terminated to the later of the following dates:
  - The date that the coverage was first obtained based on fraud or intentional misrepresentation; or
  - If the coverage is provided under an insurance contract, the date permitted under the terms of the applicable insurance contract.

- If rescission is due to your non-payment of contributions or premiums, coverage will be retroactively terminated to the later of the following dates:
  - The beginning date of the coverage period for which a payment was not received timely; or
  - If the coverage is provided under an insurance contract, the date permitted under the terms of the applicable insurance contract.

NOTE: As indicated above (see "**Important Information on Plan Eligibility**"), if coverage is rescinded, you may be responsible for any claims incurred after the date of rescission. This includes, but is not limited to, liability for benefits already paid by the plan or carrier during the period following rescission.

ENROLLMENT

You must select which contributory benefits you would like to purchase through the Plan. Your decision must be made during the annual enrollment period that takes place **before** the beginning of each Plan Year (the Plan Year is the same as the calendar year) or, for new employees, the Plan Year begins on the date that you are first eligible for benefits and ends on the following December 31.

During each annual enrollment period, you will be provided with the opportunity to change the contributory benefits that you previously elected. If you are already participating in the Plan and you fail to make an election for the upcoming Plan Year (that is, you fail to complete and submit an election form within the time periods established by the Plan Administrator), then you will be treated as having elected to waive your benefits. Additionally, by enrolling in a plan that requires contributions, you are authorizing the appropriate deductions to be made from your paycheck.

For benefits provided by the Employer that do not require employee contributions, you automatically will be covered for these benefits upon completion of the required waiting period and, if applicable, after submitting any required enrollment forms. Except as provided below, once you make (or fail to make) an

election under the Plan and the Plan Year has begun, you may not modify, alter, amend, or revoke your election until the next annual enrollment period.

When Coverage Begins

Coverage begins as follows, provided you complete and submit the necessary enrollment forms by the date indicated:

- *For newly eligible employees and their eligible dependents,* coverage begins on your date of hire or the date you meet the requirements of an eligible employee.
- *For annual enrollment,* coverage begins on the following January 1.
- *For mid-year plan election changes as a result of birth or adoption,* the change is effective on the date of the event or the loss of other coverage if you notify the MSA/MBP Benefits Administrator and request the election change no later than 31 days after this event.
- *For mid-year plan election changes as a result of marriage,* the change is effective no later than the first day of the month following the date you provide notification the of the event or the loss of other coverage if you notify the MSA/MBP Benefits Administrator and request the election no later than 31 days after this event.
- *For mid-year election changes due to a change in eligibility under either Medicaid or a state Child Health Insurance Program,* the change is effective as of the first day of the month following the date you provide notification the of the event provided you notify the MSA/MBP Benefits Administrator and request the election no later than 60 days after this event.
- *For mid-year plan election changes due to a status change (other than changes as a result of marriage, birth or adoption) as outlined below,* the change is effective no later than the first day of the month following the date you provide notification the of the event or the loss of other coverage if you notify the MSA/MBP Benefits Administrator and request the election no later than 31 days after this event. However, if the mid-year plan election change is due to a court order adding a dependent to your existing health coverage, the change will be effective as soon as administratively possible.

Mid-Year Plan Election Changes Due to Life Events

Please keep in mind that once made, your choices to receive benefits under the Plan generally must remain in effect for the entire Plan Year. However, under the following special circumstances (referred to as "life events"), you may be able to change your selected benefits during the Plan Year.

A Status Event for an employee or a dependent must affect the individual's eligibility for the Plan's benefits. Additionally, any requested change in the affected benefit must be consistent with the occurrence of the underlying Status Event. Finally, with the exception of certain changes in eligibility status under Medicaid or CHIP, mid-year plan election changes must be requested no later than **31 days** following the date of the Status Event that is the basis for the change. For changes due to either of the following a mid-year plan election changes must be requested no later than **60 days** following the date of such changes.

The notice should be submitted to the MSA/MBP Benefits Administrator. Upon receiving notification of the change in status, the MSA/MBP Benefits Administrator will send you any required forms to complete and sign. Your coverage change will be effective on the first day of the month **after** you provide timely notice to the MSA/MBP Benefits Administrator. However, if the requested change is due to the birth, adoption, or placement for adoption of a dependent child, coverage will be retroactively provided to the date of the event, again subject to timely notice of the event.

Please note that if the change request is not made within this time frame, the change may not be made until the next annual enrollment period.

Note: While the list of plan election changes is in accordance with the federal requirements for pre-tax contributions, the Plan applies the list to any plan benefits and to benefits that cover your non-tax dependent.

- ***Legal Marital/Domestic Partner Status***: Your marriage, civil union, domestic partner registration, divorce, legal separation, annulment, dissolution of civil union or domestic partnership, or the death of your spouse/domestic partner/civil union partner;
- ***Number of Dependents***: The birth, adoption, placement for adoption, or death of a dependent;
- ***Employment Status***: The termination or commencement of the employment of you or your spouse or dependent;
- ***Change of coverage under another employer's plan***: A change is made under another employer plan (including a plan of the same employer or of another employer) or an open enrollment occurs for the employee, spouse, or dependent;
- ***Work Schedule***: The reduction or increase in hours of employment or other changes in employment category of you or your spouse or dependent, including a switch between part-time and full-time, a strike or lockout, or commencement or return from an unpaid leave of absence, including a leave of absence under the Family and Medical Leave Act ("FMLA");
- ***Change in Dependent Status***: Any event that causes your dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance as provided in the health plan under which you receive coverage;
- ***Residence or Worksite***: A change in the place of residence or worksite of you or your spouse or dependent;
- ***HIPAA Special Enrollment Rights***: A change due to the requirements of HIPAA; and
- ***COBRA Eligibility***: A covered individual becomes eligible for COBRA or a state mandated continuation of health coverage benefit.

The following changes are also life events, but these life events ***only affect the medical benefit and health care spending account*** and would not entitle you to make a mid-year election change for any other coverage options:

- ***Entitlement to Medicare:*** A covered individual becomes entitled to or loses eligibility for Medicare;
- ***Entitlement to Medicaid:*** A covered individual becomes entitled to Medicaid for other than premium assistance benefits;
- ***Entitlement to Premium Assistance under a Medicaid or a state Children's Health Insurance Program (CHIP):*** A covered individual becomes eligible for premium assistance under Medicaid or a CHIP;
- ***Loss of coverage eligibility for Medicaid or CHIP:*** A plan eligible employee or dependent loses coverage under; and
- ***Judicial Order:*** A change is required by a Qualified Medical Child Support Order ("QMCSO") as described in more detail in a later section in this summary, or other judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in custody.

The following changes are also life events, but these life events ***do not apply to a health care spending account*** and would not entitle you to make a mid-year change in your health care spending account election:

- ***Automatic Changes in Your Elections:*** If the costs of certain benefits under the Plan increase or decrease during a Plan Year, the Plan may, on a reasonable and consistent basis, automatically

modify your elections to reflect this increase or decrease in costs. These automatic increases/decreases generally will occur in situations where there are small periodic changes in the costs of benefits that occur during the middle of a Plan Year (e.g., an insurance carrier makes a cost-of-living adjustment to its coverage option during the middle of a Plan Year);

- ***Significant Increase in Cost***: A *significant* increase in the cost of a coverage option may allow you to increase your contribution amount, revoke your election and elect similar coverage under another coverage option, or drop coverage if no similar coverage option is available. (Please note that under a dependent care spending account, the cost change rule only applies to cost changes required by a dependent care provider who is not a relative of the employee.);
- ***Significant Decrease in Cost:*** A *significant* decrease in the cost of a coverage option may allow you to revoke your existing election and elect coverage under such option;
- ***Significant Curtailment of Coverage Option:*** A *significant* curtailment of a coverage option that does not constitute a loss of coverage may allow you to revoke your election and elect similar coverage under another coverage option. If the significant curtailment of coverage does constitute a loss of coverage, you also may be allowed to drop coverage if no similar coverage is available; and
- ***Addition or Improvement of Coverage Option:*** If a new coverage option is added, or if coverage under an existing option is *significantly* improved, you may be permitted to revoke your existing election and elect the new or improved coverage option;
- ***Reduction in Work Hours to Less than 30 Hours****:* The reduction in hours expected to work to less than 30 hours and you enroll in another qualified health plan; and
- ***Enrollment under a qualified health plan offered by a state health insurance exchange*** **due to** an employee becoming eligible for a special enrollment period (SEP) to obtain coverage under a qualified health plan offered by a state health insurance exchange

Finally, with the exception of certain changes in eligibility status under Medicaid or CHIP, mid-year plan election changes must be requested no later than **31 days** following the date of the life event that is the basis for the change. For changes due to either of the following a mid-year plan election changes must be requested no later than **60 days** following the date of such changes.

- Entitlement to premium assistance under a Medicaid or state Children's Health Insurance Program (CHIP); or
- Loss of coverage eligibility for Medicaid or CHIP.

Again, as previously noted, if the change request is not made within this time frame, the change may not be made until the next annual enrollment period

Waiver of Benefits for Dependents

If you previously elected to waive coverage for a dependent, you will be eligible to apply for coverage for that dependent during the next annual enrollment period or, in some circumstances, during a "special enrollment" period as described above under "**HIPAA Special Enrollment"**. If you waive coverage for yourself, coverage will also be waived for your dependents. In no event will coverage be in force for your dependents if you have not enrolled in the Plan to receive similar coverage.

Special Enrollment Rights for Medical Coverage

Under certain circumstances, eligible employees who waived coverage for themselves and/or for their dependents may elect to enroll in the Plan without having to wait for the next annual enrollment period.

These special rights are provided under the Plan pursuant to HIPAA. HIPAA provides for a special enrollment period under certain circumstances, such as the following two instances:

- ***Loss of Other Coverage:*** If an employee who declines coverage for himself and/or his dependents when initially eligible because of coverage under another group health plan or insurance arrangement, and such other coverage terminates, the eligible employee and/or his dependents may elect to enroll in the Plan effective as of the first day of the month after the MSA/MBP Benefits Administrator receives the enrollment application; provided, that it is submitted within 31 days of the loss of such other coverage.

- ***New Dependents:*** If an employee declines coverage when initially eligible and subsequently acquires a new dependent through marriage, birth, adoption, or placement for adoption of a child, the employee may elect to enroll the employee, the employee's uncovered spouse (if applicable), and the employee's new dependent(s); provided that the enrollment application is submitted to the MSA/MBP Benefits Administrator within 31 days of such event with appropriate documentation reflecting this change. Coverage will be effective as of the date of the birth, adoption, or placement for adoption, or as of the first day of the month after enrolling due to a marriage, as applicable.

The booklets prepared by the insurance carriers and claims administrators will contain a more detailed description of these Special Enrollment Rights and HIPAA's rules.

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed on the attached Schedule F, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you are eligible for this benefit, one of the following procedures will apply. Please see Human Resources to determine which is applicable in your situation:

1. You will be required to pay the full applicable employee contribution amount and then you will be reimbursed by the state for the cost of your child's coverage**, or**
2. Your contribution amount will be reduced by the amount payable by the state and the Employer will collect the premium assistance amount from the state.

Automatic Medical Coverage for 31 Days for a Newborn Child or a Newly Adopted Newborn Child

If you have a child or adopt a child while you are receiving medical coverage under the Plan, your new child will automatically receive medical coverage from the date of birth/adoption for a period of 31 days. If you do not notify the MSA/MBP Benefits Administrator that you have a new child and/or if you do not apply for medical coverage for the child before the end of this 31-day period, medical coverage for your new child will terminate at the end of the 31-day period.

If you are not already receiving coverage for dependents, and if you are required to contribute toward the cost of coverage, you must apply for medical coverage (and pay any required contribution) within 31 days of having your new child in order to continue the child's coverage beyond that date. If you are already receiving coverage for dependents, you must still notify the MSA/MBP Benefits Administrator of your new child so that his/her claims can be processed. Also, if the addition of this new child changes your Plan election, i.e. "Single" to "Family," your contribution amount may be increased accordingly. If you fail to apply for medical coverage (or pay the required contribution) within the 31-day period, benefits will be payable only for covered expenses incurred by the child while coverage was in force. If you fail to timely enroll your new child during the 31-day period, coverage for your new child will cease at the end of the 31-day period and you will have to wait until the next annual enrollment period to enroll your child under the Plan.

Qualified Medical Child Support Orders

Generally, your Plan benefits may not be assigned or alienated. However, an exception applies in the case of a "qualified medical child support order" ("QMCSO"). Basically, a QMCSO is a court-ordered judgment, decree, order, or property settlement agreement in connection with state domestic relations law which either creates or extends the rights of an "alternate recipient" to participate in a group health plan, including this Plan, or enforces certain laws related to medical child support. An "alternate recipient" is any child of a Participant who is recognized by a medical child support order as having a right to enrollment under a Participant's group health plan.

A medical child support order must satisfy certain specific conditions to be qualified. You will be notified by the MSA/MBP Benefits Administrator if a medical support order that applies to you is received and the Plan's procedures for determining whether the medical child support order is qualified. You may obtain a copy of these procedures, without charge, by contacting the MSA/MBP Benefits Administrator.

Except for a QMCSO, your rights and benefits under the Plan generally cannot be assigned, sold, transferred or pledged by you or reached by your creditors or anyone else.

Rehired Employees

Unless otherwise prohibited by law, if you terminate employment and are later rehired, you may resume your participation in the Plan upon your date of hire as an eligible employee.

Contributions and Benefits during a Non-FMLA Leave

Unless communicated to you otherwise or noted below, your benefits that require a contribution will cease if you stop making contributions at any time during the Plan Year. Unless you experience a mid-year status event change, special enrollment right or cease contributions due to leave under the federal Family and Medical Leave Act ("FMLA"), you will not be able to reinstate your benefits on a pre-tax basis until the beginning of the next Plan Year.

Contributions and Benefits during an FMLA Leave

As noted above, if you take leave of absence that is approved under FMLA, you may elect to continue your benefits during the period of your FMLA leave or you may elect to discontinue your benefits. If you elect to continue your benefits while on leave, your contributions will be paid as follows.

- For periods of paid leave, contributions will be deducted from your salary as before you were on FMLA leave.
- For periods of unpaid leave, you must submit your required contributions by the first day of the month.

If you elect to discontinue benefits while on FMLA leave, you generally will be permitted to resume your benefits and to resume making contributions on a pre-tax basis. However, any claims incurred during periods when you discontinued benefits will not be eligible for reimbursement.

A more detailed description of FMLA leaves can be found in the section entitled **"FAMILY AND MEDICAL LEAVE".**

EXCLUSIONS AND LIMITATIONS

The benefits offered under the Plan are described below. However, these benefits may be limited under certain circumstances. Benefits may be limited based on the type of service provided, amounts paid on an annual basis or length of benefit periods. Additionally, some services are excluded for coverage. Please refer to the appropriate insurance carrier, claims administrator, or Employer information for a complete description of a particular benefit's exclusions or limitations. It is important to note that a benefit plan's provisions may also vary in accordance with state requirements

SCHEDULE OF BENEFITS

Employer-Provided Benefits

The following benefits are provided to you under the Plan without any required contribution. A description of these benefits is included in the booklets (this also refers to benefit certificates) provided by the insurance carriers/claims administrator (See Schedule B) who offer these benefits. These booklets are distributed to you at the time that you become eligible to participate in the Plan and are incorporated by reference under the Plan. If you have questions about these benefits, you should contact the MSA/MBP Benefits Administrator or the insurance carriers directly. The benefits that are provided by the Employer are as follows:

- basic life (benefit amounts over $50,000 will be considered imputed income);
- accidental death and dismemberment (AD&D);
- basic short-term disability (STD) (benefits will be taxed when received);
- business travel accident; and

- an employee assistance plan (EAP).

Benefits You Can Purchase on a Pre-Tax Basis

In addition to these Employer-provided benefits, you may also elect to receive other benefits and pay for them on a pre-tax basis. The advantage of paying for benefits on a pre-tax basis is that you will not pay federal income taxes (and, in most states, no state or local income taxes). The end result is that you will have a higher take-home pay than if you purchased the same coverage on an after-tax basis. However, as noted above, you may only change your pre-tax elections during annual enrollment unless you have a qualifying life event that is described under the section entitled "**Mid-Year Plan Election Changes Due to Life Events."**

The benefits that you may purchase on a pre-tax basis under the Plan are as follows:

- medical plan coverage, including prescription drugs;
- dental plan coverage;
- general purpose health care spending account; and
- dependent care spending account.

The exact plan options available to you and any required contributions will be communicated to you when you are first eligible for the Plan and during each annual enrollment period. Please remember that each benefit under the Plan has separate rules governing benefits and plan administration. These rules are set forth in the insurance carriers' and claims administrators' booklets. To the extent that you have not received them, you can request copies of these booklets by contacting the MSA/MBP Benefits Administrator or the insurance carriers directly.

Benefits You Can Purchase on an After-Tax Basis

There are also benefits that you can purchase under the Plan on an after-tax basis. The benefits that you can purchase under the Plan on an after-tax basis are as follows:

- medical plan coverage, including prescription drugs for non-tax dependents;
- dental plan coverage for non-tax dependents;
- voluntary employee life insurance;
- voluntary life insurance for your spouse and dependent children;
- voluntary accidental death and dismemberment insurance;
- voluntary accidental death and dismemberment insurance for your spouse and dependent children;
- voluntary long-term disability (LTD); and
- group legal.

Limitations on Contributions

The maximum contribution amount that you can make under this Plan is an amount equal to the total cost of electing the most expensive plan options available to you.

Nondiscrimination

It is important to note that it is not intended for the Plan to discriminate in favor of highly compensated individuals or key employees as to eligibility to participate, contributions, and benefits in accordance with Code Section 125. In order to comply with these nondiscrimination requirements, the Plan Administrator

may exclude certain highly compensated individuals or key employees from participation in the Plan, or limit the contributions made by certain highly compensated participants or key employees, without the consent of the employees.

SPENDING ACCOUNTS

In addition to the benefits that you may elect to receive as described above, you may also elect to make pre-tax contributions to a spending account(s). There are two types of spending accounts available to you: a general purpose health care spending account and a dependent care spending account. You can then use these spending accounts to pay for certain health care and dependent care expenses on a pre-tax basis.

Please remember that as noted above, the Plan Administrator may be required to limit or exclude the participation of certain highly compensated individuals or key employees, without their consent.

How Spending Accounts Work

The two spending accounts are for separate categories of expenses – one for health care and the other for dependent care expenses. You will make an election to determine how much (if any) will be contributed to your spending account(s) through periodic payroll deductions. The maximum amount that you may contribute to each type of spending account during any given year is described in the attached Schedule C. The amounts that accumulate in your spending account(s) may be used to reimburse you for certain qualifying health care and dependent care expenses that you incur during the Plan Year.

To receive reimbursement from your spending account(s), you must complete a claim form and submit it (along with copies of your receipts) to the designated claims administrator listed on Schedule B.

If a claim for reimbursement from your general purpose health care spending account is approved, you will be reimbursed the full amount of your eligible expenses up to the remaining balance of the amount you have elected to contribute for the entire Plan Year (regardless of whether such contributions actually have been made at the time your claim is submitted).

For dependent care expenses, you will only be able to make claims for reimbursement up to the amount you actually have contributed to your dependent care spending account at the time your claim is submitted.

Claims will be paid as soon as administratively possible, but not less frequently than on a monthly basis; provided, that all necessary documentation has been submitted.

After the designated claims administrator reviews the claim, you will be informed of the amount to be reimbursed. If you believe that you have been reimbursed incorrectly, you may submit a claim for benefits under the claims and appeals procedure established by the claims administrator.

Eligible Expenses Payable from Your General Purpose Health Care Spending Account

Expenses that are eligible to be paid from your general purpose health care spending account include expenses such as deductibles and copayments, uninsured medical and dental expenses, vision care, hearing care and certain other medically necessary over-the-counter (OTC) expenses. **For OTC drugs, you must provide a written prescription from a medical provider.** Generally, eligible expenses must be "medically necessary," or prescribed by a licensed physician to qualify. Covered expenses for this type of spending account *do not include* premiums paid for other health plan coverage (including plans maintained by the employer of your spouse or dependents); expenses for non-reconstructive cosmetic surgery; or expenses for personal mileage to or from a treatment facility.

For purpose of the general purpose healthcare spending account, expenses must be incurred by qualifying dependents who are individuals who meet the definition under Code 105(b) (See Schedule E for details.)

Eligible Expenses Payable from Your Dependent Care Spending Account

Eligible expenses that may be paid from your dependent care spending account must be expenses for dependent care for your qualifying dependents and must be expenses that are incurred to enable you (if single) and your spouse (if married) to work. For this purpose, qualifying dependents are those individuals who meet the definition of a qualifying dependent under Code Section 21 (See Schedule E for details.) If you have any questions regarding dependent eligibility, you should contact the MSA/MBP Benefits Administrator**.**

Examples of eligible dependent care expenses include payments to child-care centers, nursery schools, and schools for qualifying dependent children. Eligible expenses also include payment for summer **day** camps, after-school care, and elderly care. Care within your home by a relative (for whom you do not take a standard tax exemption; provided, that the relative is not a child under 19 or a spouse or a non-relative, as long as such a person is reporting payments as income), also may be eligible.

Please be aware that educational expenses to attend kindergarten or a higher grade and overnight camp expenses **are not eligible** dependent care expenses.

NOTE: You may want to consult with your tax advisor on other federal tax credits that may affect your decision to participate in the Dependent Care Spending Account.

Other Facts to Consider Regarding Spending Accounts

Although spending accounts provide you with an opportunity to pay certain expenses on a pre-tax basis, the IRS has placed some restrictions on using spending accounts:

- ***Limited Ability to Change Contribution Elections:*** Contribution elections for your spending accounts generally must remain in effect for the entire Plan Year unless you have a life event as described above.

- ***Use it or Lose it Feature to Spending Accounts:*** With the exceptions noted below, under the Plan, all spending accounts have a "use it or lose it" feature such that any excess amounts remaining in your spending account(s) after you have submitted all reimbursable claims for the Plan Year will be forfeited to the Employer. Any excess amounts in your spending account(s) cannot be combined, carried over into the next Plan Year, or converted to cash.

  So, if you choose to open a spending account, you should exercise care in estimating your reimbursable expenses for the upcoming Plan Year.

  Exception 1: For <u>general purpose health care spending accounts only</u>, you will be permitted to carry over to the next Plan Year a balance of up to **$500** any account balances over this amount will be forfeited. This amount will be added to amount you elect for the subsequent Plan Year. Additionally, this amount DOES NOT reduce the annual maximum contribution listed on the attached Schedule C.

  The rollover amount will automatically be rolled into the same type of health care spending account that you elected in the prior plan year UNLESS you submit a written request to change the type of health care spending account from either a general purpose account to a limited purpose account (this

is necessary if you will be contributing to an HSA) or from a limited purpose account to a general purpose account.

Exception 2: You may be able to receive the balance in your general purpose healthcare spending account (this exception does not apply to a dependent care spending account) as cash if you meet all of the following requirements.

- You are a reservist;
- You are called into active duty for a period of more than six months; and
- You provide a copy of your orders to the Employer.

The cash disbursement of your balance in your healthcare spending account will be subject to applicable taxes.

- ***Periodic Statements and Submission of Claims:*** When you elect to contribute to a spending account, you will be provided with instructions on how to file a claim with any supporting information. You will receive statements periodically to remind you how much money is left in your spending account(s). This money must be used for expenses incurred before the end of the Plan Year or it will be forfeited. You may continue to submit claims up to 90 days from the earlier of the date that the Plan Year ends or the date 90 days following your date of termination for expenses incurred before the date you stopped making contributions to your spending account(s).

PAYMENT OF BENEFIT COSTS

Costs for Health Coverage in Addition to Employee Contributions

If you elect to receive benefits other than the Employer-provided benefits described above, the premiums for these benefits will be paid by you through payroll deductions (either on a pre-tax or after-tax basis, depending upon the type of benefit elected). In addition to this share of the premium payments, the following is a brief description of the other types of costs that you may be required to pay under the Plan for health care benefits, but keep in mind that the exact amount of the costs will be described in the booklets prepared by the insurance carriers/claims administrator:

- ***Copayments:*** For most services, including office visits or purchasing prescription drugs, you may need to pay a flat fee known as a copayment.
- ***Deductible Amounts:*** A deductible is the amount of covered expenses you must first pay during each Plan Year before the Plan will start reimbursing you for covered expenses. The individual deductible applies separately to each covered person. The family deductible applies collectively to all covered persons in the same family. When the family deductible is satisfied, generally no further deductible will be applied for any covered family member during the remainder of that Plan Year.
- ***Coinsurance:*** Once you have paid your deductible amount, you may be responsible to pay a percentage of your medical expenses. The percentage that you will be required to pay will depend upon the type of service/benefit that is provided.
- ***Out-of-Pocket Expense Maximums:*** If the amount you pay for covered expenses reaches a certain amount, the Plan will pay 100% of any additional covered expenses for the current plan year. Please note that out-of-pocket expense maximums for network providers will not apply toward out-of-pocket expense maximums for out-of-network providers. Also, please note that certain amounts are not included in the calculation of out-of-pocket maximums. These expenses include, but are not limited to, any amounts for which you were "balance billed" (as described below) and expenses not covered under the Plan.

Your share of these costs is dependent upon the insurance plan selected and whether you use network providers or not. Network providers have agreed to accept a negotiated/discount fee for services. A network provider cannot, unless an ineligible service is provided, bill you for amounts over these negotiated rates. An out-of-network provider can bill you for expenses over the prevailing costs as determined by the Plan. This is known as "balance billing." Therefore, you generally can reduce your costs by using a network provider. You will be informed of where or how you can access the current listing of the network hospitals, physicians, and other providers when you first enroll in a health care plan. Please note that if you elect to use a Health Maintenance Organization (HMO) Plan option, out-of-network services generally are not available.

Information on network providers is available on the applicable insurance carrier website (this provides the most current list), by request to the applicable insurance carrier for a hard copy of the directory with paper updates, or by calling the applicable insurance carrier. Contact information for the insurance carrier is on the attached Schedule B.

Coordination of Benefits

If you have other coverage that is available to you (e.g., Medicare coverage or coverage under another group health plan), there may be situations where the Plan will need to "coordinate" benefits (that is, determine which coverage is primary and which coverage is secondary for purposes of paying benefits). The booklets prepared by the insurance carriers and the claims administrators contain a more detailed description about these coordination of benefits rules. If you have any questions about how these coordination of benefits rules may apply to you, you should contact the MSA/MBP Benefits Administrator or the insurance carriers and claims administrators directly.

INSURANCE CONTRACTS AND PROVIDER DISCOUNTS

Any monies refunded to the Employer due to an actuarial error in the rate calculation will be the property of and retained by the Employer. Similarly, any amounts returned to the Employer as a result of negotiated discounts with a provider or a network of providers will be the property of and retained by the Employer.

INSURANCE REBATES

Any rebates received in accordance with the Patient Protection and Affordable Care Act Medical Loss Ratio (MLR) standards will be shared with participants as follows.

- The rebate amount will be distributed as a cash amount to affected plan participants as determined by the Employer and will be subject to any applicable taxes; or

- If the rebate amount is de minimis or will result in tax consequences to either the participant or the Employer, the rebate may be used to offset the participant's future contribution amount, not to exceed the three-month period of time following the date the rebate is received.

The determination regarding which of the above methods will be used, will be made by the Plan each year based on the facts and circumstances of that year.

FEDERAL FAMILY AND MEDICAL LEAVE

Under FMLA, you may be eligible to take leave for reasons listed below with certain assurances of job security and continuation of existing health coverage while on such leave.

With the exception of leave taken to care for a seriously ill or injured Servicemember, under the federal Family and Medical Leave Act of 1993 ("FMLA"), you may take up to a maximum of 12 weeks of unpaid leave during a 12-month period for a reason listed below with certain assurances of job security and health coverage during this leave. For, leave for the care of a seriously ill or injured Servicemember, you may take up to a maximum of 26 weeks in a single 12-month period. The maximum amount of leave available is reduced by FMLA leave used for any reason during the prior 12-month period.

Definition and Terms

For this section of the Plan, the following definitions and terms apply.

"*Continuing treatment by a healthcare provider"* means any one or more of the following;

1. the employee or family member is treated two or more times for the injury or illness, either by, under the supervision of, or due to a referral by, a healthcare provider;
2. the employee or family member is treated for the injury or illness by a health care provider on at least one occasion that results in a regimen of continuing treatment under the supervision of a healthcare provider; or
3. the employee or family member is under the continuing supervision of, but not necessarily being actively treated by, a health care provider due to a serious long-term or chronic condition or disability which cannot be cured (e.g. Alzheimer's disease, severe strokes, terminal cancer).

"*Covered Active duty*" means —

1. in the case of a member of a regular component of the Armed Forces, duty during the deployment of the member with the Armed Forces to a foreign country; and
2. in the case of a member of a reserve component of the Armed Forces, duty during the deployment of the member with the Armed Forces to a foreign country under a call or order to active duty under a provision of law referred to in section 101(a)(13)(B) of title 10, United States Code.

"*Covered Servicemember or Servicemember*" means-

1. a current member of the Armed Forces (including a member of the National Guard or Reserves) who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness; or
2. a Covered Veteran who is undergoing medical treatment, recuperation, or therapy, for a serious injury or illness and who was a member of the Armed Forces (including a member of the National Guard or Reserves) at any time during the period of 5 years preceding the date on which the veteran undergoes that medical treatment, recuperation, or therapy.

"Covered Veteran" means an individual who was a member of the Armed Forces (including a member of the National Guard or Reserves), and was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran.

"Next of kin" means the "nearest blood relative" of a covered Servicemember.

"Parent" means the biological parent of an employee or an individual who stood *in loco parentis* to an employee when the employee was a son or daughter. This includes an individual who assumed "day-to-day" responsibility for a child.

"*Qualifying Exigency*" applies to any of the following activities due to or following a spouse's, a child's, or a parent's call to active duty or active duty status by the Reserves or National Guard (does not apply to state service):

1. short-notice deployment activities;
2. military events and related activities;
3. childcare and school activities;
4. financial and legal arrangements;
5. counseling activities;
6. rest and recuperation activities;
7. post-deployment activities;
8. parental care; and/or
9. additional activities.

"*Serious health condition*" is an illness, injury, impairment or physical or mental condition that involves:

1. any period of incapacity or treatment in connection with or consequent to inpatient care (e.g. an overnight stay) in a hospital, hospice or residential medical care facility;
2. any period of incapacity requiring absence from work, school, or other regular daily activities , of more than three calendar days which also involves "continuing treatment by a healthcare provider" (as defined above);
3. continuing treatment by a health care provider for a chronic serious health condition or a long-term condition that is incurable or so serious that, if not treated, would likely result in a period of incapacity of more than three calendar days;
4. any period of incapacity due to pregnancy or prenatal care; or
5. any absence to receive multiple treatments for restorative surgery or medical intervention such as chemotherapy for cancer or dialysis for kidney disease.

"Serious injury or illness" means –

1. in the case of a current member of the Armed Forces (including a member of the National Guard or Reserves), an injury or illness that was incurred by the member in line of duty on active duty in the Armed Forces (or existed before the beginning of the member's active duty and was aggravated by service in line of duty on active duty in the Armed Forces) and that may render the member medically unfit to perform the duties of the member's office, grade, rank, or rating; and

2. in the case of a covered veteran who was a member of the Armed Forces (including a member of the National Guard or Reserves) at any time during a period described in paragraph (15)(B), a qualifying (as defined by the Secretary of Labor) injury or illness that was incurred by the member in line of duty on active duty in the Armed Forces (or existed before the beginning of the member's active duty and was aggravated by service in line of duty on active duty in the Armed Forces) and that manifested itself before or after the member became a veteran and is:

    i. A continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember's office, grade, rank, or rating; or

ii. A physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service-Related Disability Rating (VASRD) of 50 percent or greater, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave; or
iii. A physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment; or
iv. An injury, including a psychological injury, on the basis of which the covered veteran has been enrolled in the Department of Veterans Affairs Program of Comprehensive Assistance for Family Caregivers.

"Son or daughter" means a biological, adoptive, or foster child, a stepchild, a legal ward, or a child of a person standing in loco parentis, who, with the exception of a seriously ill or injured Servicemember, is (1) under 18 years of age, or (2) 18 years or older and incapable of self care because of a mental or physical disability. For the care of a seriously ill or injured Servicemember, there is no age requirement.

"*Spouse*" means a husband or wife as defined or recognized by the state or country in which the marriage occurred, including common law marriage in states where it is recognized.

NOTE: While federal law does not recognize individuals who do not meet the definition of a Spouse as being covered under FMLA, the Employer has voluntarily elected to adopt the policy to treat domestic partners and civil union partners as a spouse under the FMLA rules. Therefore for the purpose of FMLA leave, wherever the term "spouse" is used, it will apply to such individuals on the same basis. However, such leave will not reduce the FMLA leave otherwise available to you but this may not apply to state leave law discussed below.

Eligibility for Leave

To be eligible for FMLA benefits, you must: (1) have at least twelve (12) months of service; and (2) have worked at least 1,250 hours during the 12-month period preceding the start of the leave.

Reasons for FMLA Leave

FMLA leave is available for the following reasons:

- the birth, adoption, or placement of a child for adoption or foster care;
- to care for an immediate family member (spouse, child, or parent) with a "serious health condition" (as defined below);
- for your own "serious health condition", which renders you unable to perform the essential functions of your position;
- for a Qualifying Exigency due to your spouse, child, or parent being on active duty or, as a member of the National Guard or Reserves, called to active duty status in support of a contingency operation; or
- to care for a seriously ill or injured Servicemember.

Amount of FMLA Leave

With the exception of leave taken to care for a seriously ill or injured Servicemember, under the federal Family and Medical Leave Act of 1993 ("FMLA"), you may take up to a maximum of 12 weeks of unpaid

leave during a 12-month period for a reason listed above. For leave to care for a seriously ill or injured Servicemember, you may take up to a maximum of 26 weeks in a single 12-month period.

Not including leave for the care of a seriously ill or injured Servicemember, the available amount of FMLA leave in any 12-month period is measured on a rolling basis backwards from the date the leave in question begins. For care of a seriously ill or injured Servicemember, the leave year is the 12-month period beginning on the date that you request leave for such purpose.

Each time you take FMLA leave, the remaining leave entitlement would be the balance of the 12 weeks or, if leave involves leave for the care of a seriously ill Servicemember, 26 weeks that had not been used during the immediate preceding 12 months. FMLA leave must be taken consecutively except that taking intermittent leave or working on a reduced schedule is permitted when medically necessary due to your own serious health condition or that of your spouse, child or parent or to care for a Servicemember.

NOTE: If both you and your spouse are employed by the Employer, are each eligible for FMLA leave, and request FMLA leave for the birth, adoption, placement for adoption or foster care of a child, or care of an ill or injured Servicemember, the two of you are entitled to a **combined total** of up to 12 or, if applicable 26 weeks of FMLA leave.

Notice and Certification Requirements

When the need for leave is known in advance, an application for leave should be submitted in writing to the MSA/MBP Benefits Administrator at least **30 days** before you want the leave to begin. When the need arises unexpectedly, notice should be given as soon as possible, at a minimum within two days of learning of the need for leave. If you request leave due to your own or a family member's serious health condition, you will be required to provide, within **15 days** of the request, medical certification from a health care provider on an Employer-provided form.

Failure to comply with certification and documentation requirements may result in a delay, a denial or revocation of FMLA leave.

Integration with Other Leave

Unless prohibited by state law, your FMLA leave may run concurrently with any one or more of the following types of leave: occasional absence, short-term disability, salary continuation, vacation and personal days. You will be notified before your FMLA leave begins if you will be required to use other available paid leave.

Any paid leave used, either as required or as you have elected, you will then be entitled to an additional period of leave on an unpaid basis for a combined total of 12 or, if applicable, 26 weeks of leave. Even absent a request for FMLA leave, the Employer may designate an absence as FMLA leave and count it toward your statutory entitlement of 12 or, if applicable 26 weeks if the Employer determines that the leave qualifies or may qualify as FMLA leave.

In addition, if you are also eligible for leave under state law, such leave will run concurrently with FMLA leave unless prohibited by state law. You can receive additional information about such state laws by contacting the MSA/MBP Benefits Administrator.

Benefits

While on FMLA leave, your health and other benefit coverage will continue under the same terms as if you were working, and you continue to be responsible for the same portion of your health premiums and for payment(s) for other Employer benefit coverage as you paid before taking the leave. During unpaid FMLA leave, you must arrange for personal payment in accordance with the provisions of the applicable plans. If a required premium is not received within **45 days** of the due date, the coverage may be dropped for the remainder of the leave. If you do not retain health benefits during an FMLA leave, coverage may be reinstated upon return from the leave on the same terms that were in effect prior to the leave, subject to any adjustments made for similarly situated employees, without any qualifying period, physical examination or exclusion for pre-existing conditions. However, any claims **will not be reimbursed** if incurred during any period during which you did not pay your required contribution and coverage was dropped for non-payment.

Except as required by COBRA, the Employer's obligation to maintain health benefits ceases upon any of the following:

- you inform the Employer of your intent not to return from leave;
- you elect not to continue health coverage during the leave;
- your required premium payment is delinquent by more than 45 days, or
- you fail to return after an FMLA leave is exhausted.

There will be no loss of seniority rights or any benefits accrued prior to the date on which leave is commenced. During an FMLA leave of absence, personal leave, sick time, holidays, and vacation time will not accrue unless you are in pay status while on FMLA leave.

Return to Work

With limited exceptions for certain "key employees," as defined by law, employees who timely return from FMLA leave, upon or prior to exhaustion of such leave, will be returned to their original or equivalent position, with equivalent pay, benefits and other employment terms. You may be required to provide a fitness-for-duty medical certification prior to returning to work if leave was taken for your own serious health condition. Such certification may also be required by the Employer whenever there is a question about fitness for duty. The Employer may require a second medical opinion, by a physician of its choice and at its own expense. Given conflicting opinions, the Employer may require and pay for a third medical opinion from a jointly selected physician.

A voluntary election not to return to work will result in termination of health coverage and an obligation to repay any health premiums paid by the Employer on your behalf during any period of unpaid leave. Repayment may not be required if the failure to return is due to a continuation, recurrence or onset of a serious health condition or other circumstances beyond the employee's control. As with any leave, a failure to return upon expiration of an FMLA leave may be treated as a voluntary resignation.

STATE FAMILY LEAVE

Generally, the Washington Family Leave Act (FLA) runs parallels with the federal Family Medical Leave Act (FMLA). The FLA entitles employees to up to 12 weeks of leave in the event of a serious health condition by the employee or a family member (defined as a "child, parent, or spouse" of an employee, or registered domestic partner.) Unless noted below, FLA leave will run concurrent with the above described FMLA leave. The following are examples of how FLA and FMLA may or may not run concurrently.

1. Women who take leave from work for pregnancy related conditions or childbirth, and who qualify for FMLA, may be entitled to additional leave benefits under the FLA. After any disability related leave has ended, the woman is entitled to 12 weeks of additional leave under the FLA for bonding with and caring for the baby. However, if the woman has any remaining FMLA leave, it will run concurrent with the FLA leave.

2. As indicated above, FLA grants employees the right to take up to 12 weeks of leave to care for a state registered domestic partner (and their children) to the same extent as a spouse. However, because the federal FMLA is not available for leave related to a registered domestic partner or their children, such leave does not qualify for FMLA leave. Therefore, such FLA leave will not run concurrent with FMLA leave.

CLAIMS PROCEDURES

The booklets and other materials that describe a particular benefit under the Plan generally will contain a specific set of claims and appeals procedures that you must follow to make a claim to receive that particular benefit and/or to appeal a denied claim for that particular benefit. Although these separate claims and appeals procedures will be very similar in most respects, there may be important differences. As such, you should follow the specific claims and appeals procedures for a particular benefit very carefully. **If the booklets and other materials that describe a particular benefit do not contain a specific set of claims and appeals procedures, the Plan's default procedures will apply, as detailed in the attached Important Notices Section under the Claim Procedure Details Notice.** If you have any questions about which set of claims and appeals procedures to follow or any other questions about making a claim, you should contact the MSA/MBP Benefits Administrator immediately.

Additionally, the Plan's health care benefits provide solely for the payment of certain health care expenses. All decisions regarding health care will be solely the responsibility of each covered individual in consultation with the personal health care provider selected by the individual. The plan and any applicable insurance contracts contain rules for determining the percentage of allowable health care expenses that will be reimbursed and whether particular treatments or health care expenses are eligible for reimbursement. Any decision with respect to the level of health care reimbursement or the coverage of a particular health care expense may be disputed by the covered individual in accordance with the Plan's claims procedure.

Covered individuals may use any source of care for health treatment and health coverage. However, the Plan and/or the Employer will **NOT** have any obligation for the cost or legal liability for the outcome of such care or as a result of a decision by a covered individual not to seek or obtain such care, other than the liability under the Plan for the payment of benefits as described by either the insurance carrier or the claims administrator.

Summary Table for Claims Procedures[1]

Type of Plan

Applicable Time Period Limit for:	**Group Health-Urgent Care**	**Group Health-Non-urgent Pre-Service**	**Group-Health-Non-urgent Post-Service**	**Long-Term Disability**	**Life and AD&D Group Legal**
The Plan[2] to notify you if it will pay the initial benefit claim request	72 hours	15 days	31 days	45 days	90 days
The Plan to extend their decision period (the initial claim period)	None	15 days	15 days	31 days (a second 31 day extension is allowed)	90 days
The Plan to notify you that the claim was not completed correctly or needs more information	24 hours	5 days	31 days	45 days	See carrier booklet/ certificate
For you to provide the missing information	48 hours minimum	45 days	45 days	45 days	See carrier booklet/ certificate
For you to appeal the Plan decision	180 days	180 days	180 days	180 days	60 days
For the Plan to respond to your appeal	72 hours	31 days (15 days if the plan has two appeals)	60 days (31 days if the plan has two appeals)	45 days	60 days
For the Plan to extend the appeal process	None	None	None	45 days	60 days

For purposes of this section that describes the Plan's default claims and appeals procedures, the Plan Administrator (or any third party to whom the Plan Administrator has delegated the authority to review and evaluate claims, such as an insurance company) will be referred to as the "Claims Administrator" at the initial claim level and the "Appeals Administrator" at the appeal level. Refer to Schedule B for details.

A request for benefits is a "claim" subject to these procedures only if you or your authorized representative files it in accordance with the Plan's claim filing guidelines. In general, claims must be filed in writing (except urgent care claims, which may be made orally) with the applicable provider identified in Schedule B. Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim) must be filed with the Plan Administrator at the address indicated in the ERISA information found in the document. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that your inquiry is an attempt to file a claim. If a claim is received, but there is not enough information to allow the Claims Administrator to process the claim, you will be given an opportunity to provide the missing information.

[1] The detailed description of the default claims procedures are included with the "Important Notices".
[2] The insurance carrier on behalf of the Plan will administer the claims procedures where applicable.

If you want to bring a claim for benefits under the Plan, you may designate an authorized representative to act on your behalf so long as you provide written notice of such designation to the Claims Administrator and/or the Appeals Administrator identifying such authorized representative. In the case of a claim for medical benefits involving urgent care, a health care professional who has knowledge of your medical condition may act as your authorized representative with or without prior notice.

External Review for Medical Claims Only

If you receive a final internal adverse benefit determination for a medical claim, you may have the right to have an external review of this decision. This means that your claim will be reviewed by health care professionals who have no association with either the insurance carrier or claims administrator who initially reviewed your claims. This is sometimes referred to as a review by an independent review organization, or IRO. Reviews may be provided for claim decisions that involve making a medical judgment as to the medical necessity or experimental and investigational exclusions, including but not limited to appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested. Upon exhaustion of the internal review process, you will receive additional information on how to submit a request for external review and where to send the request

The following is a summary of information that applies to external reviews of adverse benefit determinations. As noted in this summary, you will receive more detailed information if your denied medical claim is eligible for an external review.

1. The Plan's appeal process provides for external review of adverse benefit determinations (and final internal adverse benefit determinations) that involve making a medical judgment as to the medical necessity or experimental and investigational exclusions, including but not limited to appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested.
2. At the time of the final internal adverse benefit determination, you will be provided with a written notice of your rights to external review that includes more detailed information on the external review process.
3. Unless you meet the following criteria, you will be required to exhaust the **internal** appeal process before you may submit a request for an external review. This requirement may be waived if:
    a) the insurance company or the plan's claims administrator notifies you that it is waiving the exhaustion requirement;
    b) the insurance company or claims administrator is considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process (except those failures that are considered *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to the claimant); or
    c) you request both an expedited[1] **internal** appeal and an expedited **external** review at the same time as noted below.
4. An expedited **internal** review request can be made in situations where an adverse benefit determination involves a medical condition for which the standard timeframe for the completion of the internal appeal process would seriously jeopardize the life or health of the claimant or would jeopardize your ability to regain maximum function.

[1] In cases where an expedited review is needed, notice of the decision of the claim must be provided no later than 72 hours after the request is received for either an expedited internal and/or external review. Additionally for external reviews, the IRO must provide written confirmation of the decision within 48 hours of the decision.

5. An expedited **external** review request can be made in situations where an adverse benefit determination involves a medical condition for which the standard timeframe for the completion of the internal appeal process would seriously jeopardize the life or health of the claimant or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not yet been discharged from the facility.
6. You must be given up to four months following the date that you receive the adverse benefit determination or final internal adverse benefit determination to submit a request for external review of the medical claim.
7. Preliminary Review – Within five business days of receiving the request for external review, the insurance company or claims administrator must determine the following:
   a) if the claimant was covered under the Plan when the claim in question was incurred;
   b) if the adverse benefit determination is related to the claimant's failure to meet the Plan's eligibility requirements;
   c) if the claimant exhausted the internal appeals process if required by the Plan; and
   d) if the claimant provide all the information and forms required to process the external review.

   Within one business day after the completion of the preliminary review, the Plan must notify the claimant whether or not they are eligible for an external review. If it is determined that they are not eligible for an external review, the notice will include the reasons why the claim is ineligible and how to contact the Employee Benefits Security Administration (EBSA) at 866-444-EBSA (3272) for further assistance with your claim review. However, if the initial request was incomplete, you will be informed as to what information or materials are needed to complete the request. You will have up to the later of the end of the four-month filing period or within 48 hours of receiving notice of an incomplete request.

8. Your claim will be assigned to an independent review organization (IRO) to perform the external review. The IRO will timely notify you of its acceptance of your external review. The notice will also include a statement that you have ten business days, unless otherwise indicated, to submit any additional information that the IRO must consider when conducting the external review. The IRO has one business day to forward the additional information to the applicable insurance carrier or claims administrator.
9. Within five business days after the assignment of the IRO, the Plan will provide the IRO with the documents and other information used to make the adverse benefit determination. If the documents are not submitted timely, the IRO may terminate the external review process and reverse the adverse benefit determination or final internal adverse benefit determination.
10. The IRO must make a final external review decision within 45 days and notify the claimant within one day of such decision.
11. The IRO decision is generally binding on the claimant, as well as the plan or issuer (except to the extent those other remedies are available under State or Federal law).

Overpayment

In the event you or any other person or organization receives a benefit payment that exceeds the amount of benefits payable under the Plan, the Plan has the right to require that you, or the person or organization who received the overpayment, return the overpayment or to reduce any future benefit payment made to you (or

on your behalf) or your dependents by the amount of the overpayment. For example, you must reimburse the Plan for any improperly paid claims and all payments made on behalf of ineligible dependents. This right does not affect any other right of recovery with respect to such overpayment.

Subrogation

This provision applies whenever someone else (including your own insurer under an automobile or other policy) is legally responsible or agrees to compensate you for an illness or injury suffered by you or your dependent(s) that is covered by this Plan. If you file a claim under this Plan for benefits arising out of or related to an illness or injury due to the act of a third party, the Plan will be subrogated to any legal claim you may have against the third party. "Subrogation" means the Plan has the right to act in your place to make a lawful claim or demand against the third party.

If you receive any recovery from the third party, you must reimburse the Plan before all others for any benefits it paid relating to that illness or injury, up to the full amount of the recovery received from the other party (regardless of how that recovery may be characterized). The reimbursement required under this provision will not be reduced to reflect any costs or attorney's fees incurred in obtaining compensation unless separately agreed to, in writing, by the Plan Administrator in the exercise of its sole discretion. Any so called "make-whole doctrine," "common fund doctrine," or "attorney's fee doctrine" will not defeat the Plan's right to full recovery. The Plan may also seek restitution in equity, for example, through a constructive trust or equitable lien upon particular funds for property.

The Plan reserves the right to have you sign a statement that acknowledges your obligation to reimburse the Plan under this provision for any benefits it paid relating to such illness or injury. That obligation will arise upon the payment of any Plan benefits relating to the illness or injury, whether or not you sign such a statement.

BENEFIT TERMINATION

Your benefits will terminate in accordance with the schedule below. In addition to this schedule, your benefits will terminate on the occurrence of the earliest of the following events:

- The termination of the Plan or the amendment of the Plan to eliminate one or more benefits previously provided under the Plan;

- Your or your covered dependent's

  - inability to meet the eligibility requirements to participate in the Plan as set forth in this summary or the insurance carriers' booklets or other materials; and
  - any payroll contributions or premiums have been adjusted accordingly;

- Your revocation of your election to participate in the Plan and receive benefits under the Plan; or

- Your failure to make any contributions required to receive benefits under the Plan. (Note: In order to continue any contributory benefit during any type of leave, you will be required to continue your contributions. If you are no longer receiving a paycheck, you must remit contributions to the Plan by personal check on an after-tax basis.)

- For group legal benefits, the earlier of the date you no longer meet the eligibility requirement or the date you fail to pay the required contribution.

WHEN BENEFITS END

Event	**Medical, EAP, Dental, Vision, Health Care Spending Account**	**Life, AD&D, Vol. Life,**	**Short -Term Disability and Long Term Disability**	**Dependent Care Spending Account and Business Travel Accident**
	Coverage Terminates at the/on the	*Coverage Terminates at the/on the*	*Coverage Terminates at the/on the*	*Coverage Terminates at the/on the*
You are voluntarily or involuntarily terminated from employment	Date of termination, unless COBRA is elected	Date of termination, unless life benefit is converted	Date of termination	Date of termination
You take an approved leave for your own disability (leave will run concurrently with Family and Medical Leave Act) – This also applies to disability under Workers' Compensation **NOTE:** Nothing in this policy reduces your rights under the Americans with Disability Act (ADA) for a reasonable accommodation due to your disability.	The earlier of, the date you fail to return to work on the date your approved leave expires or six months after leave began, unless COBRA is elected	The earlier of, the date you fail to return to work on the date your approved leave expires or six months after leave began unless you convert your life benefit or you are eligible for waiver of premium	Benefits continue for as long as you are disabled as defined by the insurance carrier	Date leave begins
You take an approved leave under Family and Medical Leave Act for non-employee disability reasons	The earlier of, the date you fail to return to work on the date your approved leave expires or you inform the Employer you will not be returning to work, unless COBRA is elected.	The earlier of, the date you fail to return to work on the date your approved leave expires or you inform the Employer you will not be returning to work, unless life benefit is converted	The earlier of, the date you fail to return to work on the date your approved leave expires or you inform the Employer you will not be returning to work.	Date leave begins
You take an approved personal leave (Leave of Absence (LOA))	Date leave begins, unless you elect COBRA	Date leave begins, unless you elect to convert your life benefit	Date leave begins	Date leave begins
Your Death	On the date of your death, unless your dependents elect COBRA	On the date of your death, unless your dependents elect to convert their life benefits	On the date of your death	On the date of your death

Event	**Medical, EAP, Dental, Vision, Health Care Spending Account**	**Life, AD&D, Vol. Life,**	**Short -Term Disability and Long Term Disability**	**Dependent Care Spending Account and Business Travel Accident**
	Coverage Terminates at the/on the	*Coverage Terminates at the/on the*	*Coverage Terminates at the/on the*	*Coverage Terminates at the/on the*
You take Military Leave	Benefits continue for 31 days, and thereafter, benefits continue in accordance with USERRA (Uniform Services Employment and Reemployment Act)	Benefits continue for 31 days, and thereafter, benefits continue in accordance with USERRA (Uniform Services Employment and Reemployment Act), unless you elect to convert your life benefit	Date military leave begins	Date military leave begins
You retire	Date of your retirement, unless you elect COBRA or unless post-retirement coverage is available from the Employer and you are eligible for and elect such coverage	Date of your retirement, unless you convert your life benefit	Date of your retirement	Date of your retirement
Your child is no longer a dependent under the Plan	Date the child no longer meets the Plan's eligibility criteria, unless your child elects COBRA.	Dependent Life - Date the child no longer meets the Plan's eligibility criteria unless the life benefit is converted	N/A	N/A
You are divorced or legally separated	Date of the divorce or legal separation, unless your spouse elects COBRA.	Date of the divorce or legal separation unless the life benefit is converted	N/A	N/A

COBRA

Continuation of Coverage under COBRA

Under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"), you and your eligible dependent(s) may be eligible to continue health coverage if you or your eligible dependent(s) coverage ends because of certain "qualifying events." The following information outlines the continuation of coverage available under COBRA.

COBRA requires most employers who sponsor group health care plans to provide a temporary extension of coverage to employees and their dependents when, due to certain circumstances, coverage would otherwise terminate under the employer's plan. Under COBRA, you (or your dependents) will generally be permitted to continue the same coverage that you (or your dependents) had prior to the event that would otherwise cause the loss of coverage. This temporary extension of benefits is commonly called "continuation coverage." Here is a summary of who is eligible for continuation coverage under COBRA, when, and for how long:

These individuals	**May continue coverage if it is lost due to…**	**For up to…**
Employee	• reduction in hours of employment • termination of employee's employment for any reason other than gross misconduct • failure to return from a leave of absence under the Family and Medical Leave Act of 1993	• 18 months(1) • 18 months(1) • 18 months(1)
Covered spouse of an employee	• reduction in employee's hours of employment • termination of employee's employment for any reason other than gross misconduct • employee's failure to return from a leave of absence under the Family and Medical Leave Act of 1993 • death of employee • divorce or legal separation • employee becomes entitled to Medicare and elects Medicare as primary provider	• 18 months(1) • 18 months(1) • 18 months(1) • 36 months • 36 months • 36 months(2)(3)
Covered dependent children of an employee	• reduction in employee's hours of employment • termination of employee's employment for any reason other than gross misconduct • employee's failure to return from a leave of absence under the Family and Medical Leave Act of 1993 • death of employee • employee's divorce or legal separation • employee becomes entitled to Medicare and elects Medicare as primary provider • loss of dependent status under existing medical coverage	• 18 months(1) • 18 months(1) • 18 months(1) • 36 months • 36 months • 36 months(2)(3) • 36 months

(1) The 18-month continuation coverage period may be extended to 29 months for all covered persons if any covered person eligible for continuation coverage is disabled under the Social Security laws at any time no later than the first 60 days of continuation coverage. To qualify for this extension, the Company must be notified within 60 days of the determination that a covered person is disabled under the Social Security laws and within the initial 18-month continuation period. ***A disabled employee is considered to have terminated***

employment on the date his or her salary continuation benefits from the Company end, if the employee does not return to work.

(2) The entitlement to Medicare is ONLY a COBRA event if the entitlement does or would have caused the loss of health coverage for active employees.

(3) If an employee becomes entitled to Medicare while actively-at-work and then terminates employment, dependents will be eligible to receive COBRA coverage for the greater of the 18-month period beginning on the date of termination or the 36-month period beginning on the date the employee became entitled to Medicare.

The 18, 29, or 36 months of continuation coverage begins on the later of the date of the event that causes loss of coverage or the date coverage is actually lost.

Individuals who are eligible for COBRA coverage are called "qualified beneficiaries." The events that entitle them to coverage are called "qualifying events." Generally, to be a qualified beneficiary, you must have health coverage under the Plan on the day before a qualifying event occurs; however, a child born to, adopted by, or placed for adoption with the covered employee during the continuation coverage period is also a "qualified beneficiary."

Loss of Coverage – When a qualifying event occurs, you and the Employer have certain responsibilities. **If the qualifying event is divorce or a legal separation, or loss of dependent status, you or your eligible dependent must notify the MSA/MBP Benefits Administrator in writing within 60 days of the qualifying event**. The Employer will know if the event is death, termination of employment, reduction in hours, failure to return from a leave of absence under the Family and Medical Leave Act of 1993, entitlement to Medicare benefits[1], or the commencement of a bankruptcy proceeding.

When the MSA/MBP Benefits Administrator is notified or learns of a qualifying event, the MSA/MBP Benefits Administrator will send you or your eligible dependent(s) a written explanation of the right to elect continuation coverage.

You then have 60 days from the later of the date of this explanation or the date on which your existing coverage would end to notify the MSA/MBP Benefits Administrator of your election. If you or an eligible dependent do not respond in writing within the time limit, the right to elect to continue coverage under COBRA will be lost.

COBRA Election – Each member of a family who is eligible to elect continuation coverage may make a separate election to continue coverage, or one eligible dependent may make an election that covers some or all of the others. If you elect to continue coverage:

- You must pay a total premium equal to the group rate plus a 2% administration charge monthly (or such higher charge as may be permitted by law).[2] The total premium includes the Employer's contribution and any contribution an active participant is required to make under the Plan.

[1] The entitlement to Medicare is ONLY a COBRA qualifying event if the entitlement does or would have caused the loss of health coverage as an active plan participant.

[2] If you or your covered dependent is eligible for the additional 11 months of coverage because of disability, the premium for the additional 11 months is increased to 150% of the group rate. This increased premium may also apply through the 36th month if a second qualifying event later extends the continuation period to 36 months.

- The first payment must be made within 45 days following the date of your election and must cover the number of full months from the date coverage ended to the time of your election. Premiums for months after your election will regularly be due on the first day of the month (the "due date") and must be paid within 31 days (the "grace period") of the date due. Premium rates may change periodically for all qualified beneficiaries.

  Your coverage will continue for as long as you make payment before the end of the grace period. However, if you pay after the due date but during the grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) once payment is made. This means that any claim that you submit for benefits before payment is made will be denied until payment is made. If you fail to make payment by the end of the grace period, you will lose all rights to continuation of coverage under the Plan.

The coverage provided will be identical to the coverage provided similarly-situated employees or dependents. Should benefit levels increase or decrease, both active and COBRA participants will experience the same change.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of a qualifying event listed above. You will also have the same special enrollment rights at the end of continuation coverage if you elect continuation coverage for the maximum time period available to you.

Other Options Available to You When You Lose Group Health Coverage -

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

Benefits for Eligible Dependents – Unless otherwise specified in the election, any election of continuation coverage made by you or your spouse or former spouse will be considered to be an election of continuation coverage for any eligible dependent who would also lose coverage by reason of the qualifying event. If you elect continuation coverage that also covers your eligible dependents, these dependents may not make an independent selection of benefits until the next open enrollment period. At that time, they may change their coverage if they wish.

However, if you decide not to continue your coverage at all, each eligible dependent may make an independent benefit selection.

Changes to Continuation Coverage – Qualified beneficiaries have the same opportunities to change coverage as active employees during the annual open enrollment period. During open enrollment, you may elect different coverage or add or delete dependents, in the same manner as an active employee.

When COBRA Benefits End – Generally, continuation coverage runs for 18, 29, or 36 months, depending on the qualifying event, as described in the chart above. However, COBRA benefits will end immediately if:

- The required COBRA premium is not paid in a timely manner;

- The person whose coverage is being continued becomes entitled to Medicare benefits (this does not apply if you are a retired employee or family member entitled to purchase continuation coverage due to commencement of a bankruptcy proceeding by the employer);

- In the case of the person whose coverage is being continued under the special extended coverage period for disabled individuals, it is determined that the person is no longer disabled under the Social Security laws[1]; or

- **For healthcare spending accounts only** – If continuation of your heathcare spending account is subject to COBRA, this coverage can only be continued until the end of the plan year in which the COBRA was elected; or

- The Employer no longer maintains a group health plan covering any employee.

Two Qualifying Events – An 18-month or 29-month period of continuation coverage may be extended if another qualifying event (other than a bankruptcy proceeding) occurs during that time. However, no one may extend coverage for more than 36 months. The 36-month period is counted from the first event. For example, if your employment ends and you get divorced during the 18-month continuation period for which you have elected continuation coverage for you and your dependents, your dependents may extend coverage for up to 36 months from the date your employment ended. Please note, if the former Employee becomes entitled to Medicare, and unless the entitlement to Medicare is a terminating event for active participants, the remaining qualified beneficiaries may continue COBRA for the remainder of the 18-month period.

Other available continuation coverage – Under the Plan, you may have the right when your group health coverage ends to enroll in an individual health insurance policy with your same insurance carrier, without providing proof of insurability. The benefits provided under such an individual conversion policy may not be identical to those provided under the Plan. You may exercise this right instead of electing COBRA, or you may exercise this right after you have received the maximum COBRA continuation coverage that is available to you. You should note that if you enroll in an individual conversion policy you lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your conversion policy coverage ends.

COBRA AND MEDICARE

As noted in the above sections on "**COBRA**" and "**Medicare and Eligibility**", your Medicare status may affect your COBRA and/or Medicare coverage. The following is a summary of this information.

- If you or your spouse or your dependent child is enrolled in Medicare when a COBRA qualifying event occurs, you are still eligible to elect COBRA.

- If you or your spouse or your dependent child is not enrolled in Medicare when a COBRA qualifying event occurs, you are eligible to elect COBRA but COBRA will terminate if Medicare is elected after electing COBRA.

[1] A qualified beneficiary is responsible for notifying the Employer within 31 days of the date of a final determination that he or she is no longer disabled under the Social Security laws.

- If Medicare is elected and COBRA is terminated, COBRA is still available to any remaining qualified beneficiaries in your family.

- If you terminate employment within 18 months after becoming enrolled in Medicare, your spouse and dependent child become entitled to COBRA coverage for a period of 36 months from the date you enrolled in Medicare.

- When you are covered by Medicare AND are still not actively employed, Medicare is the primary payer of benefits and COBRA coverage is the secondary payer.

- COBRA coverage **is not** considered medical coverage based on active employment; therefore, Medicare-eligible qualified beneficiaries should understand that late premium penalties may apply if the individual does not enroll in Medicare within the time frame required upon becoming entitled to Medicare. Also there may be a delay in when Medicare coverage begins.

- COBRA is not available to your covered dependents if, while you are actively employed, you voluntarily waive group medical coverage and elect only Medicare coverage.

For additional information on Medicare benefits, enrollment rights, and premium penalties, please contact Medicare or go to the Medicare website at www.**medicare**.gov.

STATE CONTINUATION OF COVERAGE LAWS

In addition to continuation of health coverage required under federal law, you may eligible for continuation of health coverage under state law. If your health coverage is subject to state continuation of coverage law, you will be notified of these benefits.

PLAN ADMINISTRATOR

Every ERISA plan has a "Named Fiduciary" as defined in ERISA, who controls and manages the plan's operation and administration. The Plan's "Named Fiduciary" is Mission Support Alliance, LLC.

Every ERISA Plan has a "Plan Administrator" as defined in ERISA. The Plan Administrator is Mission Support Alliance, LLC Health and Welfare Benefit Committee. The name, business address, and telephone number are all included below with the rest of the ERISA information.

In general, the Plan Administrator is the one and only judge of the application and interpretation of the Plan, and has the unrestricted authority to interpret the provisions of the Plan, to resolve disputed issues of fact, and to make determinations regarding eligibility for benefits. However, the Plan Administrator has the authority to hand over or delegate certain of its powers and duties to a third party. The Plan Administrator has given over certain administrative functions under the Plan to various service providers as listed on the attached Schedule B. As the Plan Administrator's delegate, these service providers have the authority to make decisions under the Plan relating to benefit claims, including determinations as to the medical necessity of any service or supply.

The decisions of the Plan Administrator (or its delegate) in all matters relating to the Plan (including but not limited to, eligibility for benefits, Plan interpretations, and disputed issues of fact) will be final and binding on all parties and generally will not be overturned by a court of law.

AMENDMENT OR TERMINATION OF THE PLAN

Plan Amendment – The Employer will have the right to amend this Plan at any time, including the right to add or delete one or more benefits and provide additional benefits, coverages or options under this Plan.

Successor Employer – In the event of the sale, dissolution, merger, consolidation or reorganization of the Employer, provision may be made by which this Plan will be continued by the successor to the Employer. In that event, such successor will be substituted for the Employer under this Plan if the Employer consents. The substitution of the successor will constitute an assumption of this Plan's liabilities by the successor and the successor will have all of the powers, duties and responsibilities of the Employer to which it succeeds under this Plan.

Merger or Consolidation – In the event of any merger or consolidation of this Plan with any other cafeteria plan maintained or to be established for the benefit of all or some of the Participants of this Plan, the merger or consolidation will occur only if:

- Resolutions of the Employer's Health and Welfare Benefit Committee, and the governing body of any new or successor employer of the affected Participants, authorize such merger or consolidation; and
- Such other cafeteria plan satisfies the requirements of Section 125 of the Code.

Plan Termination – The Employer intends to continue this Plan indefinitely, but the Employer in its sole discretion reserves the right to terminate the Plan at any time. Upon complete or partial termination of this Plan, the rights provided in this document with respect to a Participant or other individual affected by such complete or partial termination will be terminated.

However, in the event this Plan is completely or partially terminated, any expenses incurred by an affected Participant up to the date of complete or partial termination will be reimbursed in accordance with the terms of this Plan. Any elected contribution amounts deducted from an affected Participant's compensation will be available to the Participant for any expenses incurred prior to the date of complete or partial termination until the last day of the Plan Year in which such complete or partial termination occurs. To the extent any such contributions remain after the last day of the Plan Year in which such complete or partial termination occurs, such amounts will be forfeited by the Participant in accordance with the "Use it or Lose it" provision under the Spending Account Section of this document and retained by the Employer.

COMPLIANCE WITH THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

The following information is information about the Plan that is required to be provided to you under ERISA.

Name and Identification Number of Plan

Mission Support Alliance, LLC Health and Welfare Benefit Plan, Plan Number 501

Participants

The Plan provides benefits for all employees of Mission Support Alliance, LLC who meet the eligibility requirements described herein.

Plan Sponsor

Mission Support Alliance, LLC
2355 Stevens Drive
Richland, WA 99352
509-372-1385
509-376-1404 (Fax)

Plan Administrator

Mission Support Alliance, LLC Health and Welfare Benefit Committee
2355 Stevens Drive
Richland, WA 99352
509-372-1385
509-376-1404 (Fax)

The Employer administers the Plan through the Plan Administrator who is appointed by the Employer. The Plan Administrator has overall responsibility for the Plan. From time to time, the Plan Administrator may delegate to one or more of its members the right to act on its behalf in any one or more matters connected with the administration of the Plan. The Plan Administrator is responsible for the operation and administration of the Plan, including matters relating to interpretation of Plan provisions, claims for benefits and appeals of denied claims, implementation of Plan administration procedures, and compliance with IRS rules and regulations. Benefits under this Plan will be paid only if the Plan Administrator (or its delegate) decides in its discretion that the applicant is entitled to them. In many instances, the Plan Administrator has delegated the authority to administer the Plan to the insurance carriers and claims administrators providing benefits and services under the Plan.

Employer Identification Number (EIN)

30-0419594

Type of Plan, Plan Definition, and Plan Funding

The Plan provides health and welfare benefits to eligible employees and is a "welfare plan" as that term is defined in ERISA. In some instances, these health and welfare benefits are "self-insured" (that is, the benefits are provided directly to covered individuals from the general assets of the Employer). In other instances, the benefits are provided by third-party insurers pursuant to insurance contracts between the insurer and the Employer. In addition to these benefits, the Plan also provides covered individuals with the opportunity to purchase benefits on a pre-tax basis through a Code Section 125 arrangement and the opportunity to contribute amounts to health care and dependent care spending accounts on a pre-tax basis through Code Sections 105 and 129. Both the Employer and covered employees contribute amounts toward the cost of benefits provided under the Plan.

Agent for Service of Legal Process

Mr. Jason Froggat
Davis Wright Tremaine LLP
2600 Century Square
1501 Fourth Avenue
Seattle, WA 98101-4552

Plan Year

January 1 – December 31

IMPORTANT NOTICES

1. ERISA RIGHTS STATEMENT

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored in whole or in part you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan documents or the latest annual report from the plan and do not receive them within 31 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents form the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, EBSA, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the EBSA's publications hotline.

For more information: For more information about your rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, contact the U.S. Department of Labor's EBSA in your area or visit the EBSA website at www.dol.gov/ebsa.

2. SUMMARY – PRIVACY AND SEURITY RULES

The Privacy Rules and Security Rules that are part of the Health Insurance Portability and Accountability Act (HIPAA), require that employees who elect to participate in a group health plan option receive a written notice of how an individual's health information may or may not be used without the individual's authorization and the security precautions used to protect any electronically transmitted health information.

Because the health benefits offered under the Plan include both fully insured plan options and a self-insured plan option(s) (this refers to the health care spending account), each plan option is required to provide you with a separate notice that indicates your rights and protections under the applicable health plan.

General Information Concerning Your Privacy and Security Rights under an Insured Health Plan

As indicated above, your insurance carrier will provide you with a notice that details their privacy and security policies and procedures but the following will give you some basic information.

Under the health care insurance carrier's privacy procedures, the Plan will generally only receive summary health information from the carrier. Summary health information includes, but is not limited to, information used to evaluate plan rates, pay monthly premiums, establish plan eligibility, evaluate the terms and conditions of the insurance contract, or information used for such activities as plan amendments, plan modifications, or plan terminations. In addition, enrollment information such as names, addresses, dates of birth, and dependent status, will be shared with the health care insurance carrier. The Security Rules relate to when this information is transmitted electronically.

If a Participant requests assistance with a claim issue(s), the Plan may be required to obtain written authorization from the Participant before any specific health claim information can be obtained from the health care insurance carrier. Plan Participants have the right to revoke such authorizations at any time.

Please note that the requirements of the Privacy Rules and the Security Rules do not apply to health information related to disability benefits, workers' compensation benefits, life benefits, or employment-related information (i.e. sick notes, drug tests, etc.).

Summary of the Privacy and Security Notice Related to Your Individual Medical Information under a Self-Insured Plan Option

Covered entities under the Privacy Rules and Security Rules which includes any self-insured group health plan options (again this refers to the health care spending accounts) are required to maintain the privacy of "protected health information," which includes any identifiable information that we obtain from you or others that relates to your health, your health care, or payment for your health care under a medical plan option. The Security Rules apply when this information is transmitted electronically.

The following is a summary of the Privacy and Security Notice that is included in the attached **Important Notices Section under Detailed Notice of Privacy and Security Practices.**

Uses of Protected Health Information

- The group health plan can use or disclose your protected health information for purposes of health care payment, treatment, and health care operations.

- The group health plan may disclose your protected health information to your family or friends or any other individual **identified by you in writing.**

- The group health plan will only disclose the protected health information directly relevant to their involvement in your care or payment.

- Except for certain situations, the group health plan will not use or disclose your protected health information for any other purpose unless you provide authorization. You have the right to revoke that authorization at any time.

Your Rights

- You have the right to request restrictions on the uses and disclosures of protected health information, but the group health plan is not required to agree to your request.

- You have the right to request to receive communications of protected health information by alternative means or at alternative locations.

- With some exceptions detailed in the full notice provided by the Plan, you have the right to inspect and copy the protected health information contained in a covered entity's records.

- You may request a correction to your protected health information, but the group health plan may deny your request.

- You have the right to receive an accounting of disclosures of protected health information made by the group health plan.

- Please remember this is only a summary of the information that is generally applicable to protected health information created under a health plan option offered by the Plan.

Filing a Complaint

If you believe that your privacy rights have been violated, you should immediately contact the Mission Support Alliance Privacy Officer.

Contact Person
If you have any questions or would like further information about this notice, please contact the Mission Support Alliance, LLC Privacy Officer at 509-372-8284.

3. DETAILED NOTICE OF PRIVACY AND SECURITY PRACTICES OF THE MISSION SUPPORT ALLIANCE, LLC HEALTH AND WELFARE BENEFIT PLAN

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THE PLAN'S COMMITMENT TO PRIVACY

This Notice of Privacy Practices (the "Notice") describes the legal obligations of The Mission Support Alliance, LLC Health and Welfare Benefit Plan (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The Notice is effective September 23, 2013.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information (PHI)". Generally, PHI is health information, including demographic information, collected from you, or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to the following. Please note that wherever the term health information is used in this Notice, it will mean PHI.

(1) Your past, present, or future physical or mental health or condition;

(2) The provision of health care to you; or

(3) The past, present, or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact:

MSA/MBP HIPAA Privacy Officer
Mission Support Alliance, LLC
2355 Stevens Drive
Richland, WA 99352

THE PLAN'S COMMITMENT TO PRIVACY

The Plan is committed to protecting the privacy of your PHI. The Plan also pledges to provide you with certain rights related to your health information.

By this Notice, the Plan informs you that it has the following legal obligations as required by the federal health privacy provisions contained in HIPAA, the HITECH Act, and the related regulations ("federal health privacy law" and "security rules"):

- To maintain the privacy of your health information;
- To provide you with this Notice of its legal duties and privacy and security practices with respect to your health information; and
- To abide by the terms of this Notice.

This Notice also informs you how the Plan uses and discloses your PHI and explains the rights that you have with regard to your health information maintained by the Plan. For purposes of this Notice, "you" and "yours" refers to participants and dependents that are eligible for benefits described under the Plan.

INFORMATION SUBJECT TO THIS NOTICE

The Plan collects certain health information about you to help provide health benefits to you and your eligible dependents, as well as to fulfill legal requirements. The Plan collects this information, which identifies you, from applications and other forms that you complete, through conversations you may have with the Plan's administrative staff and health care providers, and from reports and data provided to the Plan by health care service providers or other employee benefit plans. The health information the Plan has about you includes, among other things, your name, address, phone number, birth date, social security number, employment information, and medical and health claims information. This is the information that is subject to the privacy practices described in this Notice. Additionally, if this information is transmitted electronically, it is subject the Security Rules under HIPAA.

SUMMARY OF THE PLAN'S PRIVACY AND SECURITY PRACTICES

The Plan's Uses and Disclosures of Your Health Information

The Plan uses your health information to determine your eligibility for benefits, to process and pay your health benefits claims, and to administer its operations. In some cases, your health information may only be disclosed with your written authorization, while in other instances, your authorization is not required. For example, the Plan may disclose your health information, without your authorization, to insurers, third party administrators, and health care providers for treatment, payment and health care operations purposes. The Plan also may disclose your health information, without your authorization, to third parties that assist the Plan in its operations, to government and law enforcement agencies, to your family members in limited instances, and to certain other persons. The details of the Plan's uses and disclosures of your health information are described below.

Your Rights Related to Your Health Information

The federal health privacy law provides you with access to your health information and with certain rights related to your health information. Specifically, you have the right to:

- Inspect and/or copy your health information;
- Request to receive your health information through confidential communications;
- Request that your health information be amended;
- Request an accounting of certain disclosures of your health information;
- Request certain restrictions related to the use and disclosure of your health information;
- File a complaint with the Plan or the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated; and
- Receive a paper copy of this Notice.

These rights and how you may exercise them are detailed below.

Contact Information

If you have any questions or concerns about the Plan's privacy practices, or about this Notice, or you wish to obtain additional information about the Plan's privacy or security practices, contact the individual or department noted on page 1 of this Notice.

DETAILED NOTICE OF THE PLAN'S PRIVACY AND SECURITY PRACTICES USES AND DISCLOSURES

Except as described in this section, as provided for by federal, state or local law, or as you have otherwise authorized, the Plan only uses and discloses your health information for the administration of the Plan and for processing claims.

Uses and Disclosures for Payment and Health Care Operations

1. **For Payment.** The Plan may use and disclose your PHI to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

2. **For Health Care Operations.** The Plan may use or disclose your health information, without your authorization, to enable it to operate efficiently and in the best interests of its participants. For example, the Plan may use or disclose your health information to conduct audits or actuarial studies, or for fraud and abuse detection.

Uses and Disclosures to Business Associates

The Plan discloses your health information, without your authorization, to its business associates, which are third parties that assist the Plan in its operations, for treatment, payment and health care operations. For example, the Plan may share your health information with a business associate for the purpose of obtaining accounting or consulting services or legal advice. The Plan enters into agreements with its business associates to ensure that the privacy of your health information is protected from unauthorized disclosure and, to the extent electronic protected health information is shared with its business associates, such business associates will comply with the HIPAA Security Rule to the extent required by law.

Uses and Disclosures to the Plan Sponsor

The Plan may disclose health and eligibility information, without your authorization, to the Plan Sponsor for plan administration purposes such as eligibility determinations, enrollment and disenrollment activities, and Plan amendments or termination. The Plan Sponsor has certified to the Plan that it will protect the privacy of your health information and that it has amended the plan documents to reflect its obligation to protect the privacy and security of your health information.

Other Uses and Disclosures That May Be Made Without Your Authorization

The federal health privacy law provides for specific uses or disclosures of your health information that the Plan may make without your authorization, which are described below.

1. **Required by Law.** The Plan may use and disclose health information about you as required by federal, state, or local law.

2. **Additional Legal Reasons.** The Plan may disclose your health information for the following purposes:

    - For judicial and administrative proceedings pursuant to court or administrative order, legal process and authority;
    - To report information related to victims of abuse, neglect, or domestic violence; or
    - To assist law enforcement officials in their law enforcement duties.

3. **Health and Safety.** Your health information may be disclosed to avert a threat to the health or safety of you, any other person, or the public, pursuant to applicable law. Your health information also may be disclosed for public health activities, such as preventing or controlling disease or disability, and meeting the reporting and tracking requirements of governmental agencies such as the Food and Drug Administration.

4. **Government Functions.** Your health information may be disclosed to the government for specialized government functions, such as intelligence, national security activities, and protection of public officials. Your health information also may be disclosed to health oversight agencies that monitor the health care system for audits, investigations, licensure, and other oversight activities.

5. **Active Members of the Military and Veterans.** Your health information may be used or disclosed to comply with laws related to military service or veterans' affairs.

6. **Workers' Compensation.** Your health information may be used or disclosed in order to comply with laws related to workers' compensation and similar programs.

7. **Emergency Situations.** Your health information may be used or disclosed to a family member or other person responsible for care in the event of an emergency, or to a disaster relief entity in the event of a disaster.

8. **Others Involved In Your Care.** In limited instances, your health information may be used or disclosed to a family member, close personal friend, or others who the Plan has verified are involved in your care or payment for your care. For example, if you are seriously injured and unable to discuss your case with the Plan, the Plan may so disclose your health information. Also, upon request, the Plan may advise a family member or close personal friend about your general condition, location (such as in the hospital) or death. If you do not want this information to be shared, you may request that these disclosures be restricted as outlined later in this Notice.

9. **Personal Representatives.** Your health information may be disclosed to people you have authorized or people who have the right to act on your behalf. Examples of personal representatives are parents for minors, and those who have the Power of Attorney for adults.

10. **Research.** Under certain circumstances, the Plan may use or disclose your health information for research purposes, as long as the procedures required by law to protect the privacy of the research data are followed.

11. **Organ and Tissue Donation.** If you are an organ donor, your health information may be used or disclosed to an organ donor, eye, or procurement organization to facilitate an organ or tissue donation or transplantation.

12. **Deceased Individuals.** The health information of a deceased individual may be disclosed to coroners, medical examiners, and funeral directors so that those professionals can perform their duties.

Uses and Disclosures for Fundraising and Marketing Purposes

The Plan does NOT use your health information for fundraising or marketing purposes.

Uses and Disclosures of Genetic Information

The Plan is prohibited from using PHI that is genetic information for underwriting purposes with the exception of long term care insurance if offered.

Any Other Uses and Disclosures Require Your Express Authorization

Uses and disclosures of your health information ***other than*** those described above will be made only with your express written authorization, including the use or disclosure of psychotherapy notes. You may revoke your authorization in writing. If you do so, the Plan will not use or disclose your health information protected by the revoked authorization, except to the extent that the Plan already has relied on your authorization.

Once your health information has been disclosed pursuant to your authorization, the federal privacy protections may no longer apply to the disclosed health information, and that information may be re-disclosed by the recipient without your or the Plan's knowledge or authorization. However, you may revoke your authorization to use or disclose PHI, at any time by contacting the Privacy Officer. Such revocations of authorizations will be made on a prospective basis only.

YOUR HEALTH INFORMATION RIGHTS

You have the following rights regarding your health information that the Plan collects and maintains. If you are required to submit a written request related to these rights, as described below, you should address requests to the individual or department noted on page 1 of this Notice.

Right to Inspect and Copy Health Information

You have the right to inspect and obtain a copy of your health record. This includes, among other things, health information about your plan eligibility, plan coverages, claim records, and billing records.

To inspect and copy your health record maintained by the Plan, submit your request in writing. The Plan may charge a fee per page for the cost of copying your health record, and charge you the cost of mailing your health record to you. In certain limited circumstances, the Plan may deny your request to inspect and copy your health record. If the Plan does so, it will inform you in writing. In certain instances, if you are denied access to your health record, you may request a review of the denial.

Right to Request Confidential Communications, or Communications by Alternative Means or at an Alternative Location

You have the right to request that the Plan communicate your health information to you in confidence by alternative means or in an alternative location. For example, you can ask that the Plan only contact you at work or by mail, or that the Plan provide you with access to your health information at a specific location.

To request confidential communications by alternative means or at an alternative location, submit your request in writing. Your written request should state the reason(s) for your request and the alternative means by or location at which you would like to receive your health information. If appropriate, your request should state that the disclosure of all or part of your health information by non-confidential communications could endanger you. The Plan will accommodate reasonable requests and will notify you appropriately.

Right to Request That Your Health Information Be Amended

You have the right to request that the Plan amend your health information if you believe the information is incorrect or incomplete.

To request an amendment, submit a detailed request in writing that provides the reason(s) that support your request. The Plan may deny your request if you have asked to amend information that:

- Was not created by the Plan, unless you provide the Plan with information that the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information maintained by or for the Plan;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

The Plan will notify you in writing as to whether it accepts or denies your requests for an amendment to your health information. If the Plan denies your request, it will explain the reason(s) for the denial, and describe how you can continue to pursue the denied amendment.

Right to an Accounting of Disclosures

You have the right to receive a written accounting of disclosures. The accounting is a list of disclosures of your health information by the Plan to others, except that disclosures for treatment, payment or health care operations, disclosures made to or authorized by you, and certain other disclosures are not part of the accounting. The accounting covers up to six years prior to the date of your request, except that the accounting will not include disclosures of the Plan made before **April 14, 2004**. If you want an accounting that covers a time period of less than six years, please state that in your written request for an accounting.

To request an accounting of disclosures, submit your request in writing. The first accounting that you request within a 12-month period will be free. For additional accountings in a 12-month period, the Plan will charge you for the cost of providing the accounting, but the Plan will notify you of the cost involved before processing the accounting so that you can decide whether to withdraw your request before any costs are incurred.

You have the right to be notified in the event that we (or a business associate) discover a breach of unsecured PHI.

In addition, you have a right to receive reports of any security incidents that the Employer or a Participating Employer becomes aware of that is required under the Security Rules.

Right to Request Restrictions

You have the right to request restrictions on your health care information that the Plan uses or discloses about you to carry out treatment, payment or health care operations. Also, you have the right to request restrictions on your health information that the Plan discloses to someone who is involved in your care or the payment for your care, such as a family member or friend. The Plan is not required to agree to your request for such restrictions, and the Plan may terminate its agreement to the restrictions you requested.

To request restrictions, submit your request in writing, and advise the Plan as to what information you seek to limit, and how and/or to whom you would like the limit(s) to apply. The Plan will notify you in writing as to whether it agrees to your request for restrictions. The Plan will also notify you in writing if it terminates an agreement to the restrictions that you requested.

Right to Complain

You have the right to complain to the Plan and/or to the Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with the Plan, submit your complaint in writing to the individual or department noted on page 1 of this Notice.

You will not be retaliated or discriminated against and no services, payment, or privileges will be withheld from you because you file a complaint with the Plan or with the Department of Health and Human Services.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this Notice. To make such a request, submit a written request to the individual or department noted on page 1 of this Notice.

CHANGES IN THE PLAN'S PRIVACY AND SECURITY PRACTICES

Changes in the Plan's Privacy Policies

The Plan reserves its right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices as follows within 60 days of a material revision to the notice.

- If you have an email address provided by the Employer and a computer at your worksite, the revised Notice will be sent to your email address or an email will be sent noting where on the Employer's website it may be found.
- If you do not have an email address provided by the Employer or do not have a computer at your worksite, a paper copy of the revised Notice will be mailed to you at the most current home address notice noted in your employment file unless you provide written permission to send the notice to a non-work email provided by you. If such permission is provided, the revised Notice will be sent to that email address or an email will be sent noting where on the Employer's website it may be found.
- The Plan also may decide to post the revised Notice at its office locations
- In addition, copies of the revised Notice will be made available to you upon your written request. .

4. MATERNITY AND NEWBORN COVERAGE

Since the Plan offers medical benefits that include maternity and newborn coverage, you are advised that under federal law, the Plan may not restrict benefits (or fail to provide reimbursement) for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require authorization from the Plan or its administrator or the insurance issuer for prescribing a length of stay not in excess of the above periods. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

5. WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act requires that all medical plans cover breast reconstruction following a mastectomy. Under this law, if an individual who has had a mastectomy elects to have breast reconstruction, the medical plan must provide the following coverage as determined in consultation with the attending physician and the patient:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications at all stages of the mastectomy, including lymphe demas

Benefits received for the above coverage will be subject to any deductibles and coinsurance amounts required under the medical plan for similar services.

6. CLAIM PROCEDURE DETAILS

CLAIMS INVOLVING HEALTH BENEFITS

In the case of a claim involving health benefits (e.g., medical, dental, vision, EAP and health care Spending Account), unless a claim is made for urgent care, initial claims for benefits under the Plan will be made by you in writing to the Claims Administrator as listed on the Schedule B. Urgent care claims can be made orally.

- **Types of Claims** – There are several different types of claims that you may bring under the Plan. The Plan's procedures for evaluating claims (for example, the time limits for responding to claims and appeals) depend upon the particular type of claim. The types of claims that you generally may bring under the Plan are as follows:
  - *Pre-Service Claim* – A "pre-service claim" is a claim for a particular benefit under the Plan that is conditioned upon you receiving prior approval in advance of receiving the benefit. A pre-service claim must contain, at a minimum, the name of the individual for whom benefits are being claimed, a specific medical condition or symptom, and a specific treatment, service or product for which approval is being requested.
  - *Post-Service Claim* – A "post-service claim" is a claim for payment for a particular benefit or for a particular service after the benefit or service has been provided. A post-service claim must contain the information requested on a claim form provided by the applicable provider.
  - *Urgent Care Claim* – An "urgent care claim" is a claim for benefits or services involving a sudden and urgent need for such benefits or services. A claim will be considered to involve urgent care if the Claims Administrator or a physician with knowledge of your condition determines that the application of the claims review procedures for non-urgent claims (i) could seriously jeopardize your life or your health, or your ability to regain maximum function, or (ii) in your physician's opinion, would subject you to severe pain that cannot adequately be managed without the care or treatment that is the subject of the claim.
  - *Concurrent Care Review Claim* – A "concurrent care review claim" is a claim relating to the continuation/reduction of an ongoing course of treatment.

- **Time Periods for Responding to Initial Claims** – If you bring a claim for benefits under the Plan, the Claims Administrator will respond to your claim within the later of the following time periods:
  - *Pre-Service Claim* –
    - within 15 days after receipt of the claim; or
    - if the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 15-day period that up to an additional 15 days to review your claim is needed; or
    - if the extension is necessary because you did not provide the information necessary to evaluate your claim, the notice of extension will describe the information that you need to provide to your Claims Administrator and will be provided to you within 5 days from receipt of the claim. You will have no less than 45 days from the date you receive the notice to provide the requested information.
  - *Post-Service Claim*-
    - Within 31 days after receipt of the claim; or
    - If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 31-day period that up to an additional 15 days is needed; or
    - If such an extension is necessary because you failed to provide the information necessary to evaluate your claim, the notice of extension will describe the information that you need to

  - provide to the Claims Administrator. You will have no less than 45 days from the date you receive the notice to provide the requested information.
- *Urgent Care Claim-*
  - Within 72 hours after receipt of the claim; or
  - If the Claims Administrator determines that it needs additional information to review your claim, the Claims Administrator will notify you within 24 hours after receipt of the claim and provide you with a description of the additional information that it needs to evaluate your claim. You will have no less than 48 hours from the time you receive this notice to provide the requested information;
  - Once you provide the requested information, the Claims Administrator will evaluate your claim within 48 hours after the earlier of the Claims Administrator's receipt of the requested information, or the end of the extension period given to you to provide the requested information;
  - There is a special time period for responding to a request to extend an ongoing course of treatment if the request is an urgent care claim. For these types of claims, the Claims Administrator must respond to you within 24 hours after receipt of the claim by the Plan (provided, that you make the claim at least 24 hours prior to the expiration of the ongoing course of treatment).
- *Concurrent Care Review Claim –*
  - If the Plan has already approved an ongoing course of treatment for you and contemplates reducing or terminating the treatment, the Claims Administrator will notify you sufficiently in advance of the reduction or termination of treatment to allow you to appeal the Claims Administrator's decision and obtain a determination on review before the treatment is reduced or terminated.

- **Notice and Information Contained in Notice Denying Initial Claim** – If the Claims Administrator denies your claim (in whole or in part), you will be given written notice of the denial (although initial notice of a denied urgent care claim may be provided to you orally). This notice will include the following:
  - *Reason for the Denial;*
  - *Reference to Plan Provisions;*
  - *Description of Additional Material;*
  - *Description of Any Internal Rules;*
  - *Description of Claims Appeals Procedures; and*
  - *Explanation of Scientific or Clinical Basis* – If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free of charge upon request.

- **Appealing a Denied Claim for Benefits** – If the Claims Administrator denies your initial claim for benefits, you may appeal the denial by filing a written request (or an oral request in the case of an urgent care claim) with the Claims Administrator's designated Appeals Administrator within 180 days after you receive the notice denying your initial claim for benefits. If you decide to appeal a denied claim for benefits, you will be able to submit written comments, documents, records, and other information relating to your claim for benefits (regardless of whether such information was considered in your initial claim for benefits) for review and consideration. You will also be entitled to receive, upon request and free of charge, access to and copies of, all documents, records, and other information that is relevant to your appeal.

- **Time Periods for Responding to Appealed Claims** – If you appeal a denied claim for benefits, you will receive a response to your claim within the following time periods:
  - *Pre-Service Claim* – In the case of an appeal of a denied pre-service claim, the Appeals Administrator will respond to you within 31 days after receipt of the appeal.
  - *Post-Service Claim* – In the case of an appeal of a denied post-service claim, the Appeals Administrator will respond to you within 60 days after receipt of the appeal.
  - *Urgent Care Claim* – In the case of an appeal of a denied urgent care claim, the Appeals Administrator will respond to you within 72 hours after receipt of the appeal.
  - *Concurrent Care Review Claim* – In the case of an appeal of a denied concurrent care review claim, the Appeals Administrator will respond to you before the concurrent or ongoing treatment in question is reduced or terminated.

- **Notice and Information Contained in Notice Denying Appeal** – If your appeal is denied (in whole or in part), you will be given written notice of the denial (although initial notice of a denied urgent care claim may be provided to you orally or via facsimile or other similarly expeditious means of communication). This notice will include the following:
  - *Reason for the Denial;*
  - *Reference to Plan Provisions;*
  - *Description of Any Internal Rules;*
  - *Description of Claims Appeals Procedures; and*
  - *Explanation of Scientific or Clinical Basis.*

The appealed decision will be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law. If you challenge this decision, a review by a court of law may be limited to the facts, evidence and issues presented during the claims procedure set forth above. The appeal process described herein must be exhausted before you can pursue the claim in federal court. Issues not raised during the appeal will be deemed waived.

CLAIMS NOT INVOLVING HEALTH BENEFITS

In the case of a claim not involving health benefits (e.g., life, AD&D, business travel accident, Short-Term Disability (STD), Long-term Disability, and Dependent Care Spending Account), initial claims for benefits under the Plan will be made by you in writing to the Claims Administrator.

- **Time Periods for Responding to Initial Claims (non-disability)** – If you bring a claim for benefits under the Plan, the Claims Administrator will respond to you within the later of the following schedule:
  - 90 days after receipt of the claim; or
  - if the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 90-day period that the Claims Administrator needs up to an additional 90 days to review your claim.

- **Time Periods for Responding to Initial Claims (disability)** – If you bring a claim for benefits under the Plan, the Claims Administrator will respond to you within the later of the following schedule:
  - 45 days after receipt of the claim; or
  - if the Claims Administrator determines that additional time is necessary to review your claim, the Claims Administrator will notify you within the initial 45-day period that the Claims Administrator needs up to an additional 31 days to review your claim.

- **Notice and Information Contained in Notice Denying Initial Claim** – If the Claims Administrator denies your claim (in whole or in part), the Claims Administrator will provide you with written notice

of the denial. This notice will include the following (please note that the description for the italicized phrases will apply whenever the phrase is used in this section on Claims Procedures):

- *Reason for the Denial* – the specific reason or reasons for the denial;
- *Reference to Plan Provisions* – reference to the specific Plan provisions on which the denial is based;
- *Description of Additional Material* – a description of any additional material or information necessary to complete the claim and why such information is necessary and a statement that you are entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your claim and/or appeal;
- *Description of Any Internal Rules* – a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request; and
- *Description of Claims Appeals Procedures* – a description of the Plan's appeals procedures and the time limits applicable for such procedures (such description will include a statement that you are eligible to bring a civil action in federal court under Section 502 of ERISA to appeal any adverse decision on appeal and a description of any expedited review process for urgent care claims).

- **Appealing a Denied Claim for Benefits** – If the Claims Administrator denies your initial claim for benefits, you may appeal the denial by filing a written request with the Appeals Administrator within 60 days (180 days in the case of a claim involving disability benefits) after you receive the notice denying your initial claim for benefits. If you decide to appeal a denied claim for benefits, you will be able to submit written comments, documents, records, and other information relating to your claim for benefits (regardless of whether such information was considered in your initial claim for benefits) to the Appeals Administrator for review and consideration. You will also be entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your appeal.

- **Time Periods for Responding to Appealed Claims** – If you bring a claim for benefits under the Plan, you will receive a response within 60 days (45 days in the case of a claim involving disability benefits) after receipt of the claim. If it is determined that an extension is necessary due to matters beyond the control of the Plan, you will be notified within the initial 60-day period that up to an additional 60 days (45 days in the case of a claim involving disability benefits) is needed to review your claim.

- **Notice and Information Contained in Notice Denying Appeal** – If the claim is denied (in whole or in part), you will be given written notice of the denial. This notice will include the following
  - *Reason for the Denial;*
  - *Reference to Plan Provisions;*
  - *Description of Additional Material;*
  - *Description of Any Internal Rules;* and
  - *Description of Claims Appeals Procedures.*

The appealed decision of the Plan will be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law. If you challenge this decision, a review by a court of law may be limited to the facts, evidence and issues presented during the claims procedure set forth above. The appeal process described here must be exhausted before you can pursue the claim in federal court. Issues not raised during the appeal will be deemed waived.

7. IMPORTANT PLAN INFORMATION CONCERNING YOUR GROUP HEALTH HMO MEDICAL BENEFITS AS A GRANDFATHERED PLAN

The Mission Support Alliance, LLC Health and Welfare Benefit Plan, which include group health plan benefits, believes the Group Health HMO health coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan or policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at:

MSA/MBP Benefits Administrator
Mission Support Alliance, LLC
2425 Stevens Center Place
P.O. Box 650, H2-24
Richland, WA 94352

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

8. DESIGNATION OF PRIMARY CARE PROVIDERS BY PARTICIPANTS OR BENEFICIARIES

The Group Health HMO plan requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Group Health at 1-888-901-4636 or www.ghc.org.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Group Health or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Group Health at 1-888-901-4636 or www.ghc.org.

SCHEDULE A
SCHEDULE OF BENEFITS

Non-Contributory Benefits	Tax Status of Benefits
Basic Life	Premiums Paid for Benefit Amounts in excess of $50,000 Included in Taxable Income; Proceeds Not Usually Taxed
Accidental Death and Dismemberment	Benefits Not Taxed
Short-Term Disability	Benefits Taxed when Received
Employee Assistance Plan	Benefits Not Taxed
Business Travel Accident	Benefits Not Taxed

Contributory Benefits (1)	Employee Cost Per Pay	Tax Status of Contributions
Employee Medical Options (Including prescription drugs)		
Single	(2)	Pre-tax/Post-tax
Employee + 1	(2)	Pre-tax/Post-tax
Employee + 2 or more dependents	(2)	Pre-tax/Post-tax
Dental Plan Options		
Single	(2)	Pre-tax/Post-tax
Employee + 1	(2)	Pre-tax/Post-tax
Employee + 2 or more dependents	(2)	Pre-tax/Post-tax
Voluntary Long-Term Disability	(2)	Post-tax Only
Supplemental Life	(2)	Post-tax Only
Dependent Life	(2)	Post-tax Only
Voluntary Accidental Death and Dismemberment	(2)	Post-tax Only
Voluntary Accidental Death and Dismemberment - Dependent	(2)	Post-tax Only
Group Legal	(2)	Post-tax Only
Dependent Care Spending Account	See Schedule C	Pre-tax Only
Health Care Spending Account	See Schedule C	Pre-tax Only

(1) The exact insurance provider and Plan benefits offered will be communicated to participants during the annual enrollment period and to employees when they first become eligible for the Plan.
(2) The exact amount of any required contributions will be communicated to participants during the annual enrollment period and to employees when they first become eligible for the Plan.

SCHEDULE B
INSURANCE CARRIERS AND CLAIMS ADMINISTRATORS [1]

CARRIER/ADMINISTRATOR	FUNCTION	CONTRACT NUMBER	FUNDING	BENEFITS COVERED
Group Health Options, Inc. 1009 N. Center Parkway Kennewick, WA 99336 1-888-901-4636 www.ghc.org	Medical/RX Insurer	6453500 4015200	Fully-insured	Medical and prescription drug Group Health HMO and Access PPO
Delta Dental of Washington 611 N. Perry Street, Ste 200 Spokane, WA 99202 1-800-554-1907 www.deltadentalwa.com	Dental Insurer	09385	Fully-insured	Dental
United Health Care 8220 San Pedro NE Suite 300 Albuquerque, NM 87113 1-877-341-7849 www.myuhc.com	Flexible Spending Account Administrator	717203	Self-funded	Health Care FSA Plan, Dependent Care FSA Plan
CIGNA/Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192 800-732-1603 www.cigna.com	Life and Disability Insurer	SGD601313 VDT601179 SGM601429 SOK600820 ABL962332	Fully-insured	Short Term Disability, Long Term Disability, Basic Life and Employee/Dependent Life, AD&D, Business Travel Accident
United Behavioral Health 8220 San Pedro NE Suite 300 Albuquerque, NM 87113 1-800-788-5614 www.liveandworkwell.com	EAP Administrator	702633	Fully-insured	EAP
CountryWide PrePaid Legal 1060 Kings Highway N. Suite 205 Cherry Hill, NJ 08034 1-856-667-1133 www.countrywideppls.com	Group Legal Administrator	2246	Full-insured	Group Legal

(1) This schedule provides a description of coverage options and insurance carriers as of January 1, 2015. Available coverage options and insurance carriers may be changed at any time by the Employer.

SCHEDULE C
SPENDING ACCOUNTS

Employee Election	Annual Minimum	Annual Maximum
Healthcare Spending Account	$120	$2,550[(1)]
Dependent Care Spending Account	$120	$5,000[(2)(3)]

(1) Any heath care spending account balance amounts that are rolled over from a prior plan year are not included in determining the annual maximum amounts.

(2) This amount must be reduced by any amounts your spouse is also contributing to an employer dependent care spending account.

(3) The maximum amount is reduced to the least of the following amounts:

- **The amount noted above, annualized it is $5,000;**
- **$2,500 annually if you are married and filing separately;**
- **Your monthly income;**
- **Your spouse's monthly income; or**
- **If your spouse is a full-time student or unable to care for themselves, $250 per month for care of one dependent or $500 per month for the care of two or more dependents.**

SCHEDULE D
PARTICIPATING EMPLOYERS [(1)]

Mission Support Alliance, LLC

SCHEDULE E
DEFINITIONS OF DEPENDENT
UNDER THE INTERNAL REVENUE CODE
FOR THE PURPOSE OF PLAN BENEFITS

The following is a summary of the definitions for dependents under the Code as they apply to individuals who also may be eligible for Plan benefits.

1. SEC. 152. DEPENDENT DEFINED FOR TAX PURPOSES

A Code §152 dependent is either a "qualifying child" or a "qualifying relative."

- A *qualifying child* is an individual who (a) bears a specified relationship to the employee (relationship test); (b) has the same principal abode as the employee for more than half of the year (residency test); (c) meets certain age requirements (age test); (d) has not provided more than half of his or her own support for the year (limited self-support test); and (5) has not filed a joint tax return (other than only for claim of refund) with his or her spouse for the year (marital/tax filing status test).
- A *qualifying relative* is an individual (a) who bears a specified relationship to the employee (relationship test); (b) whose gross income is less than the exemption amount in Code §151(d) (income test); (c) with respect to whom the employee provides over half of the individual's support (support test); and (d) who is not anyone's qualifying child.
- *Individuals Who Generally Are Ineligible Under Code §152.* An individual generally will not be a Code §152 dependent if he or she is a dependent of a Code §152 dependent, a married dependent filing a joint tax return, or a citizen or national of a country other than the United States.

2. SECTION 105(b) DEPENDENT FOR HEALTHCARE COVERAGE

Code §105(b) establishes the requirements that an individual must meet in order to be an employee's tax dependent for health coverage purposes. In order to be a Code §105(b) dependent, an individual must meet most, but not all, of the requirements to be a "qualifying child" or a "qualifying relative" under Code §152 as noted above

Specifically, the following individuals still can be an employee's tax dependents for health coverage purposes even though they **do not** meet the following criteria that otherwise apply to Code §152 dependents.

- There is no gross income limit. The employee only has to provide Code §105(b) dependent with more than half of the dependent's support.
- If married, the employee and Code 105 dependent do not have to file joint returns.
- The individual can be a Code §105 dependent if either a U.S. citizen, U.S. national or U.S. resident alien of the United States, or a resident of a country contiguous to the United States (Canada and Mexico) (exceptions exist for certain legal adoptions).

In addition, an employee's child who is under age 27 as of the end of the taxable year can obtain health coverage on a tax-free basis, even if the child does not qualify as the employee's tax dependent under either Code §152 or Code §105. Tax-free coverage can be available through the end of the calendar year in which the child attains age 26. The age limit, residency, support, and other tests that would otherwise have to be met in order for an individual to qualify as a tax dependent under the Code do not apply to such a child for purposes of the tax-favored treatment of health coverage that is available under Code §105(b).

3. HOUSEHOLD AND DEPENDENT CARE CREDIT

The Household and Dependent Care Credit is a nonrefundable tax credit available to United States taxpayers. Taxpayers that care for a qualifying individual are eligible. The purpose of the credit is to allow the taxpayer (or their spouse, if married) to be gainfully employed. This credit is created by 26 U.S.C. § 21, section 21 of the Internal Revenue Code (IRC).

The following is an overview of the eligibility criteria for a dependent under IRC 21. Employees may want to contact a tax or legal advisor to determine if an individual meets the requirements listed.

General Eligibility Requirements

IRC Section 21 uses the term "qualifying individual" rather than "dependent" to refer to the types of dependents that may permit an employee to receive a tax credit related to the care of the dependent. Qualifying individuals must be in one of the following groups:

- Dependents under age 13 for whom a dependency exemption may be claimed [(1)];
- Dependents of any age who share the same principal place of abode as the taxpayer and are physically or mentally incapable of taking care for themselves;
- Spouses of any age who share the same principal place of abode as the taxpayer and are physically or mentally incapable of taking care for themselves; or
- Certain dependent children of divorced parents.

Additional Eligibility Requirements

The taxpayer must "maintain the household" for the qualifying individual(s), which means the taxpayer must furnish over 1/2 of the total cost of maintaining the household. In addition, if the taxpayer is married, both the taxpayer and their spouse must have earned income, unless one spouse was either a full–time student or was physically or mentally incapable of self–care.

[1] A taxpayer can claim a dependency exemption for a dependent under the age of 13 if the dependent is the taxpayer's child, sibling, half-sibling, stepsibling or a descendant of any such individual. The qualifying child must not provide more than 1/2 of his or her own support and must have the same principal place of abode as the taxpayer for more than six months of the year.

SCHEDULE F
LIST OF STATES OFFERING ASSISTANCE FOR MEDICAL COVERAGE

If you live in one of the following states, you may be eligible for assistance paying your employer health premiums. The following list is current as of July 31, 2015. Contact your State for more information on eligibility.

ALABAMA – Medicaid	**GEORGIA – Medicaid**
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://www.in.gov/fssa Phone: 1-800-889-9949
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831

MASSACHUSETTS – Medicaid and CHIP	NORTH CAROLINA – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633	Website: http://www.dhs.state.pa.us/hipp Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability

UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 15, 2015, or more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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